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ABSTRACT

The second annual educational workshop concerned utilization of psychiatric technicians for technical service to allied professions. Manuscripts are included for the following presentations: (1) "Brief History of Colorado Psychiatric Technicians Association" by Francis L. Hedges, (2) "Hominology--The Approach to the Whole Man" by Theodore C. Kahn, (3) "Motivation Through Life Enrichment" by Calvert R. Dodge, (4) "Role-Identity of the Psychiatric Technician" by Larry Austin, (5) "Innovations in Mental Health Training--Educational Panel" by Richard C. Ingraham and Catherine LaSalle, (6) "Operant Conditioning Program at Porterville State Hospital" by Robert G. Thompson and Kent L. Kilburn, (7) "The Cultures and Psychiatry" by Sydney G. Margolin, (8) "A Community Problem: The Need for Specialized Group Homes" by Evelyn Todd, and (9) "Goals of NAPT" by William L. Grimm. Two-year curriculums for mental health workers and psychiatric technicians are appended. (CH)

New Frontiers in Psychiatric Technology

Presentations of the Second Annual Education Workshop in Pueblo, Colorado, on the Utilization of the Psychiatric Technician for Technical Service to Allied Professions.

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HOMINOLOGY – THE APPROACH TO THE WHOLE MAN

MOTIVATION THROUGH LIFE ENRICHMENT

INNOVATIONS IN MENTAL HEALTH TRAINING

OPERANT CONDITIONING

CULTURES AND PSYCHIATRY

NEED FOR SPECIALIZED GROUP HOMES

GOALS OF NAPT

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National Association of Psychiatric Technology
and
Colorado Psychiatric Technicians Association

PRICE $1.75

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NEW FRONTIERS
in
PSYCHIATRIC TECHNOLOGY

"Utilization of the Psychiatric Technician for Technical Service to Allied Professions"

Presentations made at the
Second Annual Educational Workshop,
of the
Colorado Psychiatric Technicians Association
April 9-13, 1969
Pueblo, Colorado

Compiled and edited by
Zoltan Fuzessery, Director of Research and Publications, NAPT
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PREFACE

The Second Annual Educational Workshop of the Colorado Psychiatric Technicians Association, April 9-13, 1969, offered a new world of promise to the psychiatric technicians who came from hospitals hundreds and even thousands of miles away. Fourteen states across the nation sent delegates to Pueblo, Colorado, to attend the five-day interest-packed sessions. The Workshop was an excellent example of the outstanding programming that technicians can achieve. The work had been hard – but the smoothness of the operation indicated that the effort had been well focused. The Colorado Psychiatric Technicians Association had done a tremendous job in gaining the support of the staff of the local hospitals and colleges and the members of the community in putting on a major production that did justice to the progressive theme of the Workshop "New Frontiers in Psychiatric Technology."

The welcoming address was given by Bob Hermmann, Ph.D., executive assistant to Superintendent Charles Meredith of Colorado State Hospital. His inspiring remarks were directed to the new role of the psychiatric technician in community mental health. He saw the technician's community communication role similar to that of the public health nurse. The psychiatric technician in this special program at Colorado State Hospital is used as a liaison between the traveling treatment teams from the hospital, the mentally ill out-patient and the many community mental health agencies. His work involves teaching the public about matters of mental health and the agencies which serve them, monitoring the medication of the out-patients, interviewing the prospective client and his family and arranging for pre-admission interviews. In this capacity the psychiatric technician serves as a bridge from the hospital to the community to reach the people who need help.

Dr. Hermmann challenged the group to seek this expanding role. "With the added emphasis given now to more education for psychiatric

technicians, commensurate increases and responsibilities surely must follow."

The world of reality that was shown to the technician was not confined to the wards and clinics. He was reminded that he had a responsibility for making his needs known to his legislators and to the community. His influence and work cannot be confined solely to the medical scene but must be applied to bringing about laws and regulations that would improve patient treatment and rehabilitation through the better utilization of psychiatric technicians. In addition, as a responsible citizen who has special knowledge and appreciation of the urgency of the mental health problem, he should actively participate in community volunteer programs to gain support for local mental health programs.

It was an occasion for participants in the previous workshop to renew friendships, and for new participants to be guided to programs and people that would provide some of the answers they were seeking. It was above all an opportunity to become a part of the new developments which will have an increasing impact upon the progress of mental health.

The determination expressed by so many to return to Pueblo for the 1970 Workshop was evidence of the success of Colorado Psychiatric Technicians Associations' Workshop of 1969.

Zoltan Fuzessery
NAPT Director of
Research and Publications

ACKNOWLEDGEMENTS

Many persons, in addition to those whose presentations appear in this booklet, contributed to the success of the Second Annual Educational Workshop, sponsored by the psychiatric technicians of the Colorado Psychiatric Technicians Association. It would have been impossible to provide the clinical workshop experience without the gracious and encouraging cooperation of the Colorado State Hospital, Parkview Episcopal Hospital, REEJ Clinic, and the Mental Retardation Center at Pueblo. We wish to particularly thank the individuals in these facilities who were assigned to give guidance and instruction to our workshop participants regarding their special areas of activity. In the Colorado State Hospital professionals in a number of divisions and centers participated. Among them were Dr. A. C. Dones, George Tippin, A.C.S.W. and Val Croll, R.N. of the Admissions Division; Dr. T. Halpern of the Alcoholic Treatment Center; Jimmy D. Williams, A.C.S.W. of the Children's Treatment Center; Dr. A. M. Davison, of the Psychogeriatric Division; George Stock, psychologist, Mrs. Grace K. Kushihashi, A.C.S.W., Dr. Don H. Cole, psychiatrist and Mrs. Evelyn Wolfe, D.C.N. of the Security Division.

The Mental Retardation Center programs in operant conditioning were described to our visitors by Robert M. Perry, psychologist, and Dr. Carl Roberts. It served to compiement the formal presentations on operant conditioning by the guest speakers from Porterville State Hospital, California.

The varied roles of the psychiatric technicians in a number of the geographical divisions of Colorado State Hospital were described by Robert Kuhn, A.C.S.W., Mrs. Betty Ward, D.C.N., Dr. Anne C. Courtright, Dr. Alfredo Yap and Dr. Gregario Kort. The adjunctive therapies (industrial therapy, occupational therapy, recreational therapy, and vocational rehabilitation) and their relationship to psychiatric technology were given form and substance by the many able therapists. Finally the psychiatric technicians were able to learn about the new roles of technicians in mental health at Parkview Episcopal through the personal on-site guided tours of Dr. C. David Jones, chief of the department of psychiatry.

We are particularly indebted to Arthur Pearl, Ph.D., professor of education at the University of Oregon for his stimulating and

provocative ideas in "The Need to Think Big," and to Colorado State Representative Thomas T. Farley, Mr. Art Jones, A.C.S.W., Colorado State University, the panelists from Colorado State Penitentiary; Virginia West and Mrs. Tommy Thompson of the Colorado Association for Mental Health for their discussions on special subjects of personal and professional concern to the psychiatric technicians.

Needless to day, the workshop would never have come into being without the imagination, enthusiasm and unstinting efforts of many individual psychiatric technician members and officers of the Colorado Psychiatric Technicians Association who planned and organized the program.

Anabele Miller*
President, CPTA

**Editorial note: Anabele Miller was elected President of the National Association of Psychiatric Technology at the October 1969 Convention-Institute in Los Angeles.*

A BRIEF HISTORY of the COLORADO PSYCHIATRIC TECHNICIANS ASSOCIATION

by

Francis L. (Ted) Hedges, Corresponding Secretary*
Colorado Psychiatric Technicians Association

*President CAPT 1969-70

The Colorado Psychiatric Technicians Association was founded in August, 1960, as an alumni association of graduate psychiatric technicians at the Colorado State Hospital in Pueblo, Colorado.

It resulted from a suggestion by Mrs. Elizabeth Bartley, R.N., Assistant Director of Nursing at the hospital. She saw the possibilities for technicians to improve the quality of patient care by banding together and pooling their talents and resources to further their own education and improve their skills. Nine individuals responded to her suggestion and the Association became a reality. After incorporation, membership requirements were relaxed and non-graduate technicians were permitted to join. With this strength, the group then persuaded the hospital to send *all* technicians to their training program. As a result, almost 100 percent of the C.P.T.A. members are graduates of this, or another, training program. In the process, membership increased in less than nine years to approximately twelve hundred members.

The growth in membership and the changing needs led the Association to seek passage of a licensure law during 1964. The first attempt failed. A primary cause was that the group and its intentions were little known in the state. To overcome this, the Association initiated a two-year campaign to publicize itself and its goals. As a result, the second attempt to pass a law met with almost no opposition. Thus, in January, 1969, mandatory licensure for all psychiatric technicians became an operational law in the state of Colorado.

The law brought with it many new problems, and the C.P.T.A. rapidly became involved in these problems. There were individuals and groups who attempted to circumvent the law. This problem continues to the

present day. The law itself was found to be far from ideal because the ever-changing needs caused some sections to be obsolete while other sections were in doubt. Large areas of psychiatric technician duties and activities were completely ignored by the law. Small pockets of overt opposition to a licensure law for our discipline continued to remain. The Association, therefore, assumed a new role of being, to some extent, the policeman of its own licensure law.

With its recently acquired role of being a part of the social community, the Association then became interested in some philanthropic projects. In 1964 it donated one thousand dollars and the same number of memberships to the Pueblo Mental Health Association. At a later time, one hundred dollars was appropriated to purchase tickets to the Shrine Circus for the benefit of crippled children. In 1968, three hundred fifty dollars was channeled to the Suicide Prevention Program in this area. In this same year, another fifty dollars was donated to the Colorado State Hospital Auxiliary to help pay for bus rides for hospital patients to view the local Christmas decorations and lights. Early in the present year, another fifty dollars was used to purchase tickets for a benefit sponsored by the Pueblo Association for Retarded Children. The tickets themselves were then donated to and used by the residents of the Mental Retardation Center at the Colorado State Hospital.

Another of its successes was to win the National Association of Psychiatric Technology Perpetual Membership Trophy for the past two years. If the C.P.T.A. can win this trophy for the third straight year, it then becomes its permanent possession. Approximately four hundred fifty of the local members now belong to this national association.

To further their own programs and goals and to help the emerging field of Psychiatric Technology, the local allied themselves with the national association at an early date. The number of delegates and representatives from the local to the national conventions gradually increased from one through the years to twenty at the last convention. Correspondence and other communication increased even more rapidly. At present, the Colorado Association has been designated as the headquarters for the Region 8 of the National Association, and in this capacity it serves to disseminate information and assistance to growing numbers of similar associations in neighboring states.

Not forgetting its original goals, the Association has fostered the educational development of its own members. It has been involved in setting up a psychiatric technician program at the Southern Colorado State Collge; this replaced the one at the hospital. In the present program, progress can be made through steps which culminate in an Associate of Arts Degree in Psychiatric Technology. This program is constantly being changed to meet the present needs, and the Association is active in these adjustments.

A large percentage of the local members is enrolled in this college on an independent basis and is pursuing further education in general as well as closely related subjects. Moreover, consultants from the local have served on committees and task forces and been invited to various areas of this state as well as out of state to help improve patient care by improving the quality of the psychiatric technician.

Another milestone of growth occurred in August of 1967 when the office of the Colorado Psychiatric Technicians Association was moved from a rented room in a building at the Colorado State Hospital to its present location in the American Legion Hall at 415 North Grand Ave., in Pueblo, Colorado.

With this additional independence and increased facilities, the Association began to move toward even larger activities. No one knows who first proposed the idea, but late in 1967 a future educational workshop began to be considered. Early in the following year, a handful of members with a tongue-in-cheek attitude, launched the effort which produced the first educational workshop ever to be conducted for this discipline by psychiatric technicians themselves.

Hard work and unexpected assistance of many kinds, including financial help, made this first endeavor a tremendous educational success. The exchange of ideas between the technicians and members of other disciplines who came from various states throughout the nation contributed to this achievement. Full cooperation of hospital administrations as well as the help from local agencies and business firms, helped to make this possible.

This experience, success, and the subsequent favorable press reports, served to motivate the Colorado Psychiatric Technicians Association to conduct an even larger and better workshop in 1969.

HOMINOLOGY – THE APPROACH TO THE WHOLE MAN

Theodore C. Kahn, Ph.D.
Professor of Behavioral Science
Southern Colorado State College

Theodore C. Kahn, Ph.D. Anthropology, Ph.D. Psychology, is currently Professor and Head of the Department of Behavioral Sciences at Southern Colorado State College.

Dr. Kahn was formerly Chief Psychologist for the United States Air Force, and developer of The Kahn Test for Symbol Arrangement; the Kahn Intelligence Test; and The Group Personality Projection Test.

While Chief Psychologist at Wilford Hall Hospital, Lackland Air Force Base, San Antonio, Texas, he developed the Science of Hominology, and subsequently authored the book "An Introduction to Hominology". Dr. Kahn is world-known in his fields and listed in "Who's Who."

Since you are Psychiatric Technicians, it may be of interest to you to know that hominology was born in a medical setting. However, while it was but an infant, it moved from the hospital to a college campus. In 1964 the one thousand bed Wilford Hall Hospital at Lackland Air Force Base in San Antonio, Texas, initiated a new program for the training of psychiatric residents. This program was affiliated with the new University of Texas Medical School at San Antonio. With the development of a new program and a new institution for teaching medicine, there was much talk about searching for new ways of doing things, of new ideas, of new concepts; such as treating the total person who has a disease instead of treating the disease as if it existed outside of the person himself.

As the Chief Psychologist at Wilford Hall Hospital, I was asked to prepare a series of lectures on psychology for psychiatric residents, stressing the whole person. After some inquiries we found that the local universities could not furnish us with an anthropologist for our teaching program. Knowing that I had taught anthropology at San Antonio College, the director of the psychiatric residency program asked me also

to give a series of lectures in anthropology. Again I was asked to stress the whole man aspect from this orientation. I had barely had time to recover from the shock of this added responsibility when I got the sad news that due to the loss of the social worker who had agreed to teach sociology for the program, I would also be obliged to teach this subject in addition to the two others.

Now, I like teaching, but I was dismayed at the need to divide myself up into so many compartments: psychology, anthropology, and now also sociology. The questions that I asked myself were: Am I not spreading myself too thin in dividing myself into these three vital areas of human concern, psychology, anthropology, and sociology? How could I teach the whole man concept which the psychiatric residents required in all three disciplinary areas? How could I do justice to psychology and to sociology and at the same time to anthropology? I bemoaned my fate and planned rebellion until I suddenly realized that I had fallen into a trap of my own making. I recognized this as a disciplinary trap. I was doing the very same thing in my thinking about the courses as was the physician who thought about the disease in man instead of about the man who had the disease. I was thinking in narrow, disciplinary terms instead of focusing on the basic purpose of my assignment which was the whole man.

It is the man himself that we were interested in recognizing, understanding, and evaluating and not the disciplines that grew up around him thousands of years after human beings had already arrived on earth. It dawned on me that instead of worrying about whether I could do justice to the disciplines, I should be worrying about whether I could do justice to man himself. I should be worrying about non-fragmented man instead of non-fragmented disciplines. In order to teach the whole man in a non-fragmented way, I would have to combine all of the pertinent knowlege on the subject without concern for disciplinary sources involved. I realized that the view of total man would require facts from psychology, anthropology, sociology and from other disciplinary areas and that these would have to be integrated.

Hominology began when the hospital staff enthusiastically supported the idea of integrating the variety of areas dealing with man. We knew

that it might lead to criticism from those who saw themselves as the guardians of the traditional disciplinary boundaries. However, once the decision was made, there was no turning back. The entire psychiatric staff of the hospital, including some of the new professors at the medical school, attended a meeting to discuss the integrated approach. As we explained what we were attempting to do, I could sense the mounting enthusiasm and even excitement at the idea of participating in something new and revolutionary in the effort to understand and explore human nature.

We called the approach "hominology" after the word *hominidae* which means a family of mankind, now and in the past, as it emerged throughout time. The name implies that in order to understand mankind's behavior today, we must attempt to understand where mankind came from historically and how he got there biologically. In modern psychiatry it is obvious that when a patient comes in with something like claustrophobia, we as diagnosticians do not ask him what he did yesterday or today. Instead, we explore the patient's childhood and infancy as well as his recent history. For locked in the remote past of the patient's early childhood may be the etiological factor that would explain the claustrophobic symptoms he is displaying in adulthood. So in hominology we look into mankind's infancy in order to get hints and clues about his nature, to view him in a more meaningful manner, and to understand the puzzling phenomenon we call human behavior.

Fate intervened and hominology was not taught at the medical school nor in the psychiatric residency program as planned. For personal reasons we had to move to a less humid climate than San Antonio; and in 1965, I received in invitation from Southern Colorado State College to teach hominology there if I could adapt it to fit into the curriculum designed for college students. The hospital and medical school at San Antonio have kept me on as a consultant, and I have periodically given a number of lectures on hominology to the psychiatric staff there since living in Colorado. So, if one wished, one might say that the embryo of hominology developed in San Antonio; but the birth of the child took place in Pueblo with a few occasional visits back to the womb.

As this approach developed during the past four years that the subject has been taught at Southern Colorado State College five distinguishing characteristics have been noted:

1. Hominology is non-disciplinary and non-specialized.

2. Hominology explores abstractions such as man's ethics, his morality, his values, and his religions.

3. Hominology concerns itself with man's past, present and future.

4. Hominology encourages self-understanding and provides a means for achieving this. This self-understanding is not psychological, but rather psycho-philosophical. That is, it represents an exploration of the self-image within the framework of goals and values.

5. Hominology does not offer any prescription or dogma which the student must follow, instead it provides reference points and frameworks to assist the student in charting his own way.

All this begins with self-discovery and ends in an attempt to explore undivided, unfragmented man. Please note that I say attempt. We are not deluded to the point of thinking that this unfragmented picture of man can be discovered and identified easily. The very tools we use with which to study him distort the object of our search. Neverthless, as many behavioral scientists will agree, the attempt to find total man, that is to discover the human essence, is a worthy effort in itself even if in the end we cannot meet with complete success. The search will enable us to obtain a deep appreciation of the difficulties of this effort; and at the same time, it will provide us with a concept of what it means to be a human being.

The attempt to understand human moral values and put these into a behavioral science framework has evoked most of the criticism we have encountered. On this subject, I would like to give you a quotation from a recent issue of a report by Carl Menninger in *Frontiers of Hospital Psychiatry*. He writes:

> As scientists traditionally we are careful to keep value systems out of our thinking. We do not permit ourselves to say one patient is good and one is bad. We may call him names indicating that, but we would not say so. We don't hate syphilis, we just fight it. We don't dislike delusions, we just point out to their victims that they are mistaken. We don't condemn suicide or drug addiction, we just deplore that they exist and ask for some explanations. We take the

attitude that we must not make moral judgment about the goodness and badness of behavior, but I think that we must make some judgment of this kind. I think we kid ourselves about attempting to maintain objective, neutral scientific detachment.

Many scientists now agree with Dr. Menninger. Moral values and ideas of right or wrong cannot be swept under the rug as not pertinent to psychology or psychiatry in the contemporary world. As scientists, professionals, or therapists we must pull moral values and ethics out of the closet where we have hidden them so long. We must incorporate a study of moral values within the general framework of total man. How can we today think of total man without thinking at the same time of human values, human dignity, human hopes, and human concepts of what is right and what is wrong? It is not enough to explore what makes a human being human as such writers as Morris have done. We must also try to understand what it is that makes man human. It is not enough to understand that man as a mammal gets his milk from his mother's breast; but even more essential, we must continue to search for the source of the milk of human kindness and human compassion. It is only through such a search that we can hope to find the whole man, this creature who surpasses all living things in his capacity to hate and who at the very same time, surpasses these same living things in his capacity for boundless love and devotion. We are searching for man, the riddle. In hominology we believe that if we ever hope to solve that riddle, we must have all the pertinent facts. We cannot do it by confining ourselves to one discipline or stressing one at the expense of another. Hominology offers reference points and frameworks. Let us look at some of these.

Geologists and biologists have developed a frame of reference which enables them to have intelligIbe communication. They have categorized the evolution of life into an age of fishes, an age of amphibians, an age of reptiles, an age of mammals, and so on. Within hominology we have found it necessary to also have some subdivisions in order to view man's development historically and communicate about it. We have divided human development into the Eight Ages of Man.

Time does not permit me to go into detail, but let me say that the anxiety that we see in the world today stems from the fact that we are

presently between the sixth and the seventh development levels or ages of man. The sixth level has its focus on the fulfillment of personal needs whereas the next level, the seventh, has its focus satisfying the needs of others. We are caught in the dilemma of "taking" versus "giving" and are torn by a desire to serve our own needs and at the same time to dedicate ourselves to humanity. Within hominology the moral values are not viewed as existing in a vacuum but are rooted within mankind's emergence and are seen as coming into existence as an aid to help mankind emerge from one level and enter into the one that followed. Thus the duties are associated with man's sixth developmental level. Fulfillment and the dedications relate to the seventh level of mankind which he is reaching for at this very moment.

In evaluating morality, Menninger and others insist that students must learn that we cannot pursue one of the moral values at the expense of the other. Many well-meaning young people of today fail to recognize this necessity. Let us remember that a dedication is a voluntary act, be it large or small, in which we attempt to help other people. Let us say, for example, that a student holds an elevator door open for another student so that the student can enter the elevator after the doors have started to close. Since he is not required to do this, it represents a dedication. If, however, he continues to stand there and hold the door open for other students, missing his class, his dedication has become meaningless since he performed it at the expense of his duty to be present in his classroom. If a man assists his neighbor's children as a dedication but in doing so neglects his duty to help his own children, his dedication becomes senseless. Such a dedication, to be meaningful, would require that he first provide for the needs of his own children and then help other children in his neighborhood as his time and his capacity permits. We know this can be done because we are acquainted with many scout leaders and workers in boys' clubs who are doing this effectively and not at the expense of helping their own children.

The modern parent feels guilty because in a highly technical society, young people do not have the opportunity to dedicate. They are, therefore, being deprived of the need to be "up-to-date." In terms of mankind's developmental progress, we fail to give young people anything to dedicate with or dedicate for. Recklessly, then, some throw themselves into dedication without benefit of our guidance; and these

confused young people are then like rudderless ships, seeking non-existing shores. Giving young people a meaningful way to help others is one of the great challenges of today.

The study of hominology ends by the examination of ten of the most pressing problems with which the contemporary world is concerned; among these are the increase of mental illness and personality maladjustment, the role of individual freedom and its survival within a complex society, poverty, over-population, current problems of parenthood, and increase in crime especially among today's youth. Within hominology, these problems are examined in a non-disciplinary fashion; and we believe they are given new and wider perspectives which place them within the total picture of mankind emerging. These are the problems which one examines in the final chapter of the book, *An Introduction To Hominology — The Study of the Whole Man.*

William Sheard, a psychiatric technician, is among your group. While he was taking a course in hominology he did a research project on the application of hominological ideas within the Northeastern Division of the Colordo State Hospital. Another psychiatric technician whom you certainly all know is Ted Hedges who spoke so kindly about me at the introduction. In May of 1968, he completed a research paper in which he utilized the hominological self-exploration techniques and applied these to the specific duties and professional opportunities available to those who work with the mentally retarded. I cannot do justice to the work of these two colleagues by merely quoting sections of their research; but nevertheless, I would like to read to you how Ted Hedges began his paper and then read how Bill Sheard ended his. At least it will give you an idea what others, men from your own group, have been able to accomplish and perhaps this will have more meaning to you than anything I can possibly tell you.

Ted Hedges began his paper with the following introduction:

> It shall be the attempt of this paper to show by description how a group of mental health workers may use hominology as their primary approach to patient care. This group is presently referred to as psychiatric technicians. While the very nature of their work is non-disciplinary, only a handful have studied the non-disciplinary

approach. This approach is a fundamental concept of hominology's study of total man.

The rest of the study by Ted Hedges is fascinating reading. I regret that time only permits the introductory sample.

Bill Sheard ends his paper as follows:

> To summarize, there seems to be a relatively high utility value in the hominological approach in the treatment program of the Northeastern Division of the Colorado State Hospital. A questionnaire distributed to the personnel of this Division corroborates the author's hypothesis. This study indicates that hominology is practiced as a reality in conducting everyday affairs and is considered a positive trend in the treatment of the mentally ill. Since treatment isn't disciplinary but, indeed, hominological, it seems pertinent that hominology gain wide acceptance as a concept in our educational system throughout the United States. For only with this wider and more global view can we truly understand each other and reduce to a minimum the biological, environmental, and sociological differences that may lead to our own annihilation.

Ladies and Gentlemen, I cannot think of a more fitting ending than this conclusion reached by Bill Sheard, one of your own psychiatric technicians; and, therefore, I shall stop right here.

Note: The book, *An Introduction to Hominology* by Dr. Kahn may be obtained from Charles C. Thomas, Publishers, 301-327 East Lawrence Ave., Springfield, Ill. 62703. A series of four exercises called *Charting the Self-Image* are an inherent part of the hominology experiment and these may be obtained by mailing $3.00 to the Midwest Educational Press, 131 So. Union St., Pueblo, Colorado 81003.

MOTIVATION THROUGH LIFE ENRICHMENT

By Calvert R. Dodge

Calvert R. Dodge is the employee training specialist at the Colorado Division of Youth Services, Fort Logan, Colorado.

He received his B.S. in Agriculture and an M.A. in Sociology from the University of Wyoming. He is now a Ph.D. candidate in Communication Methodology at the University of Denver. He has served in teaching positions at both these universities before assuming his present assignment in 1964. His activities have been closely associated with working with young people. He has served as a consultant at the Nevada Juvenile Services Youth Camp, and consultant trainee, Federal Bureau of Prisons, Robert Kennedy Youth Center, and Office of Economic Opportunities, Job Corps Training Center. His assignments have also included director of youth and educational activities in 15 states while employed with a commercial organization.

From my interpretation of the theme of this year's Psychiatric Technicians Workshop, I am going to assume that many of you have some motivation towards helping others for one reason or another.

Since part of your theme deals with "service to allied professions," it may also be inferred that you are saying to those of us working with delinquent youth, "How can we help these 'kids' who are in or out of institutions?"

Some ideas may develop within your own mind after you hear or read the following bits and pieces of information.

The handwriting concerning the future of large institutions housing delinquent youth is on the wall. These huge establishments, costing millions of dollars, have never been able to show a profit in success with human lives. Nationally, 36 out of every 100 persons released from correctional institutions are in trouble with the law again within a short time.[1] Some delinquent youth institutions in the United States have a rate of returnees within the first year as high as 80%.

In Colorado, two youth camps, each housing 48 youths under 18 without any locked doors, have a researched predicted returnee rate as low as 8%.

The time has come then to focus on the entire correctional process, especially as it relates to juveniles. Coupled with this is the point that our rehabilitation and treatment techniques, especially in the more progressive states such as California, New York, Washington and Oregon, will become more and more focused within the community. Colorado does not intend to be left behind. The youth may continue to live at home under a rehabilitative program utilizing therapy techniques for him and involving his peer group and his family. He may remain in his neighborhood in some other small unit program or he may come to our camps. The very last resort for the hardest-to-reach delinquent will be the then less big, cold cottages of a distant institution. Those of us who are faced with making these major changes in our approach to the juvenile delinquent must realize that we must develop community facilities and attempt to enlist the help of associative professions such as the psychiatric technicians; that much of our effort must also be devoted to involving the entire community in developing a new attitude toward delinquents and toward those who work directly with them in the rehabilitation process.

How can we in the field of delinquency motivate you to help — especially since your tires were slashed last night by a snot-nosed 14-year-old, and a smart-assed 17-year old stole your car's gasoline and broke the windshield the night before and his father later told you to "go to hell."

Before answering this question and while you recover your own "helping services attitude" for the job ahead, some expansion of this idea of community program should be made.

As a result of millions of dollars of federally financed experimental projects aimed at discovering what America needs to do to lower its delinquent youth population, we have arrived at approximately the same conclusions as the Swedes did about 50 years ago and Egyptians did about 4,000 years ago. That is, we have concluded that the cure is usually spatially located at the point of cause — the community which includes family, friends, and neighbors.

We may try to blame space problems, God or TV and its ability to spread the news of delinquent fads across the country in a few moments, but scientifically-founded research proves differently.

One of the currently significant youth programs is the California Community Treatment Program. It compared the parole records of youth placed in institutions with those of delinquents who receive community treatment. The controls received "regular" institutional treatment and were then paroled. The experimentals were released directly to their home communities, where their social, recreational, and other activities were closely supervised. They received individual counseling, remedial education, and help in finding jobs. The delinquents treated in the community have made significantly better parole records than those who were institutionalized, and psychological tests show that they have made more improvement in their personal and social adjustment.

At Essexfields, New Jersey, and at Provo, Utah, two programs for delinquent youth are serving as models for numerous treatment programs now in operation throughout the country. Each program concerns itself with a population of 20 boys. The boys, who might otherwise have been institutionalized, were permitted to live at home, work a full day, and participate in a series of regular group discussion sessions that utilized the technique of guided group interaction. Guided group interaction is a technique of living whereby the adults set the value system up over a period of from 12 to 24 months and live by this system. The delinquent youth through peer-group involvement begin to adapt and accept this new *postive* culture system with its higher values. When a new boy enters the group with his negative values, he soon learns to accept and live by the new positive value system. Group discussions are held by the youth-peer group with the discussion facilitator which could easily be a psychiatric technician sitting outside of the group circle and only serving as a resource person when needed or as a mediator in extreme conflicts.

In South Carolina a program is developing where public offenders are being treated as disabled people. Through its programs it has been able to reduce returnee rate as low as 8 percent.

Successful programs, whether they include Provo, Utah's;[2] Essexfields, New Jersey's; or California's Community Treatment Projects, all include one very important feature.

The most important feature is that the youth participants were permitted to remain in the community where their problem began. The concept of our nation's most successful youth rehabilitative programs was that change in behavior patterns would not be restricted by artificial setting such as are found in large institutions. The spotlight of the successful programs was on the here and now.

Goals included:

1. Giving the delinquent group a stake in what happens to its members by permitting participation with adults in solving problems, exerting controls, and making basic decisions. To psychiatric technicians this methodology is old stuff.
2. To open up opportunities to delinquents in school, work, and other conventional community programs.
3. To guide the delinquent group towards total involvement in change so that shared standards, points of view, rewards and punishments, are a part of the "new" peer group culture.

In my own investigations of community-based delinquent youth rehabilitation projects while visiting in France, Germany, the Netherlands, and England, I witnessed the development of one other important goal – that is, the involvement of mother, father, sisters and brothers, uncles and cousins in the rehab process.[3]

In Sweden the very largest institution has only 80 youths. In Denmark no institution has more than 100. The more ideal units range from 5 to 20 youth.[4]

With the preceding information, the handwriting on the wall tells us that more qualified persons such as the psychiatric technicians will be called upon to assist in the new era of community-based delinquent youth rehab programs. But how, when, where, and why?

The how may include anything, from serving with a halfway house staff one night a week on T-group work, to organizing a weekly probationer

and family self-awareness program, to managing an entire project as a special project director for a week or a month. During this time you may or may not be paid by your regular employer for this community service.

When and where depends on your own motivational stimuli.

The why question seems to be a fitting one for the conclusion of my talk with you since it relates closest to the title of the talk and the theme of your conference.

Dr. Fredrick Hertzberg,[5] professor of psychology at Western Reserve University, is "doing his thing" in the area of MOTIVATION through job enrichment. His research has demonstrated that man foundering in our gigantic sea of cybernetics is desperately seeking higher values out of his existence than shorter hours, longer vacations, more pay, more fringe benefits, and other "hygiene" factors.

As these "hygiene" factors continue to rise in the land of plenty, cities and humans continue to crumble.

Hertzberg and others of his caliber have found that what a man does for his fellowman and for himself, his achievements in life, recognition, responsibility, professional growth are the "real" MOTIVATING factors in increasing his production as well as satisfaction. These factors are somewhat related to Abe Maslow's self-actualized person factors.

Nowhere in the helping service will you as a professional, as a psychiatric technician, find greater job enrichment than in the area of community-based delinquent youth prevention, control, and treatment programs.

But as you will note, I substituted the word "life" enrichment for "job" enrichment in the title.

I will conclude on this note. Before you can ever be successful in your own mind's eye, you must be willing to become involved in this "life-enrichment" concept. You must believe in yourself and the ability you now have. You must become more aware, accept yourself and

others, become more creative, and, in general, begin to trust yourself and others as you move towards goals in life.

Without this value you will be useless in your efforts with delinquent youth. They soon detect your "sham", your "insincerity," your "flight or fright syndrome."

This was never so clear to me as it was last fall when I had participated in week upon week of sensitivity and self-awareness programs and had become deeply involved with "self-enrichment" projects with Pueblo Indians and duplicated these challenging trust relationships with a group of 17-year-old, two-timers at Lookout Mountain School for Boys in Golden, Colorado.

Two years ago I would have been somewhat apprehensive to be too close to these tough guys and now I was trusting enough in myself and others to perform these challenging trust exercises. The peak-out of self-enrichment could never be better illustrated to me as a 185-pound lad closed his eyes and stiff-legged dropped backwards into my arms held a few inches above the floor as evidence of his trust in me. This trust exercise, familiar to psychodrama specialists, was extremely significant in triggering changes in my own attitude and behavior towards others.

As a psychiatric technician, you are closer to value, beauty, imagination, ethics, and joy, as well as creativeness and love, and thus closer to being able to work in the community with delinquent youth.

As your motivational powers increase your interest, then, perhaps, you will want to contact your local juvenile judge, your local chief probation counselor, and others in the community to help develp the methodology.

If you accept the challenge, I feel certain that the motivation will remain with you and that your own life will be greatly enriched.

Welcome to the era of community-based, small-group delinquent youth programs.

1. Switzer, Mary E., Administrator, Social and Rehabilitation Services, U. S. Department of Health, Education, and Welfare, in an article from *TRIAL,* April, 1968, HEW, Washington, D. C.
2. Ibid, page 1.
3. Ministere De La Justice, Director De L'Education Surveillee Rapport Annuel (Annual Report) a M.Le Garde Des Sceaux, 1964.
4. Tunley, Roul, *Kids, Crime and Chaos,* World Report on Juvenile Delinquency, Dell Publishing Co., 1962, Chapter 15.
5. Hertzberg, Fredrick; *Motivation Through Job Enrichment;* Bureau of National Affairs, 5615 Fishers Lane, Rockville, Maryland 20852.

ROLE-IDENTITY OF THE PSYCHIATRIC TECHNICIAN

By Dr. Larry Austin

Lawrence E. Austin, M.D. is a psychiatrist at Colorado State Hospital in Pueblo, Colorado. At present he is the director of professional education at the hospital. Prior to this assignment he was the director of the West Central Division of the hospital.

Born in Salt Lake City, Dr. Austin completed his undergraduate studies at the University of Utah in 1958. His graduate work and medical schooling was at the University of Colorado. His M.D. degree was awarded in 1963 by University of Colorado Medical School. He completed a three-year residency in psychiatry, 1964-1968, at the University of Colorado. Since early 1969 he has been a clinical instructor in psychiatry at the University of Colorado.

He is a member of the American Medical Association, the American Psychiatric Association, Pueblo County Medical Society and the Colorado Psychiatric Association.

It is indeed a pleasure for me to welcome you to the second day of your workshop as I do feel very closely identified with the psychiatric technician. I came from one of the largest psychiatric training centers in the country, the Colorado Psychiatric Hospital, which has trained a number of the most eminent psychiatrists. This I say because I was amazed when I came to the state hospital to find the difference between the aide, as he is called at the medical school, and the psychiatric technician at the state hospital. When I came to the state hospital I had expected to find that the majority of patients were going to be treated by untrained personnel such as I had experienced before. It was my delight to find, instead, that the Psychiatric Technicians brought a high level of expertise to their jobs. With a great deal of fondness I remember that first year of working with them and discovering the wonderful qualities they displayed in patient relationships.

After my initial half year at the state hospital, however, this led to my deep concern with the lack of professional identification which the psychiatric technician had at our hospital. I was asked one night to

speak to the Colorado Psychiatric Technicians Association and I remember very vividly that night asking the psychiatric technician who he was. We spent a lot of time writing on the board – who was the psychiatric technician – what did he see himself doing. I share with you now the feeling of real depression I had as I listened to some of the technicians describe what they did. They saw themselves as bed-pan emptiers, bed makers, key carriers, etc. But in the midst of this type of sentiment, a small but vocal group of people insisted that they were more than that – and indeed they were. I tried to share with them who I thought they were, what I thought they could do and now as I return to the state hospital after two years, I sense a new professional identity of the psychiatric technician which I attribute to your very fine association. Our psychiatric technicians, those with whom I am personally familiar now, see themselves as trained, qualified people who are fulfilling a specific duty at a specific time.

But now I think that the psychiatric technicians associations must do some propagandizing for themselves. I think that you have developed a sense of professional identity and have developed professional competence, but I think this is not shared nationally. In looking through the two most recent textbooks of psychiatry, I fail to find anyting of significance which describes the function of the psychiatric technician. As the mental health profession is discussed, there is talk about manpower needs, about psychiatrists, about psychologists, about social workers, about nurses (described as mental health professionals). In fact, thirteen pages are used to describe what these people do, and then in the very last paragraph there is a note that the individual with whom the patient is most familiar and with whom he deals almost exclusively, is the psychiatric technician – and then the chapter is closed.

I think that there is failure on the part of the psychiatric technicians associations nationally if they cannot convince the national leaders in manpower to recognize the need for trained psychiatric technicians in the very substantial role in the treatment of our psychiatrically ill population. I think it goes without saying that we cannot begin at this point to meet the professional manpower needs for the mentally ill population in the United States. At this time, if every psychiatrist in the United States treated one hour once a week every alcoholic in the United States who belonged to Alcoholics Anonymous, then treated

those alcoholics who did not belong to Alcoholics Anonymous, there would not be any time left over for them to treat anyone else. That's how critical the shortage of mental health men is. Obviously the psychiatric technician, out of necessity, must play an important role in this treatment program.

I think we are living in a period of transition, a transition in treatment in which mental hospitals are receding, communities are developing their own programs and the national trend is to treat the psychiatric patient where he lives and when he needs to be treated.

A nationally known educator and clinician, Milton Greenblatt, has emphasized this present trend of psychiatry to treat illness where it manifests itself and when the patient needs help. He believes that we, as a mental health body, cannot any longer sit back in our isolated cubicles and talk about individual psychodynamics and psychopathology, but rather we must understand the people we're dealing with, the environment they are living in, and the politics which dictate their lives. As I review the program in which you have been participating for the past two days, I see an acknowledgement of this trend. In your program you are not discussing individual dynamics and individual pathology, but are broadly studying cultural values, education programs, and the total picture. I commend the leadership of this workshop for its intuitive and broad approach to your needs.

At this point it is imperative that each of you assess your own role as a psychiatric technician whether that be in a mental health center or in a state hospital, a private hospital, a representative of a mental health team working in the community, or whatever, for I think there is a problem. I think there is a difficulty in the identity of the individuals.

Yesterday when I went to our library at the state hospital – which we consider to be one of the most progressive in the country, dedicated to good patient care and effective utilization of the psychiatric technician, I was appalled to find in the library of at least 2,000 volumes, that there is *one* textbook for the psychiatric technician – and it was checked out. This is a failure on the part of the psychiatric technicians at the state hospital not to make it known that they need books of their own. There are six shelves of books for the psychiatric nurse, and

several shelves on psychotherapy, but only *one* book specifically for the psychiatric technician. I think you ought to go back to that hospital and do something about it.

I am reminded by the blurring of the roles of psychiatric technicians of the poem with which you are no doubt familiar, "The Blind Men and the Elephant" by John Godfrey Saxe. Each of the blind men came in contact with a different part of the elephant's anatomy. The one who felt the beast's solid, broad, rough side thought the animal very much like a wall. The second, touching the tusk, likened it to a spear. The others had equally dissimilar ideas of what this "thing" was.

I think that has relevance to how you see yourselves and how other people see you. I think some people see you as the tail, some see you as the fan, and some see you as the spear. I think it is your responsibility as psychiatric technicians to make it clear, nationally, who you are and what you are. Thank you.

EDUCATION PANEL
"INNOVATIONS IN MENTAL HEALTH TRAINING"

by Dr. Richard C. Ingraham, Ph.D.
Metropolitan State College, Denver

Richard C. Ingraham, Ph.D. is currently affiliated with the University of Oregon at Eugene as Associate Professor, Community Service, in the School of Community Service and Public Affairs.Dr. Ingraham's under-graduate work was completed at the University of Nebraska where he majored in psychology, sociology and English. His graduate work was done at the University of Missouri, where he obtained his Master of Arts degree in the field of social psychology and his Doctor of Philosophy degree in clinical psychology and collateral field Community Development.

From 1965 till 1967 he was employed as a clinical psychologist in Missouri and in Colorado and in 1967 became the Director of the Helping Services Program and NIMH Mental Health Worker Grant, at Metropolitan State College in Denver, Colorado. He has also served in the capacity of consultant to various schools and hospitals and was in private practice at the University Park Psychological Center in Denver.

I'd like to just go on right where Dr. Austin had left off. He said some very beautiful things, and things are happening, believe it or not. Sometimes out here in the middle of the prairie in Colorado it is hard to know what is going on elsewhere in the world and maybe this is a part of the problem to which Dr. Austin is referring. Traditionally, in state hospital settings, an aura of provincialism develops. When you first came to work as a psychiatric technician, you not only didn't know much about the broad field of mental health, the problems involved, but you didn't know what was going on in other places in your state, in our country and in the world. This has hampered, certainly, the growth of the psychiatric technicians or mental health workers at your particular level. But things are happening. I was very pleased to obtain, just before we began today, a publication of the National Association of Psychiatric Technicians, "Community Mental Health and the Psychiatric Technician".[1] It would be valuable for you to obtain this book because it tells you what is going on nationally in your own disciplines.

We, at Metropolitan State College represent only a small attempt in the effort to aid in the development of this new discipline – Mental Health Technology. It's not new to you who have been working in this field for years and years, you who have dedicated your life with helping people with emotional problems. But because it's not written up in the psychiatric textbooks, nor in psychological, social work, or nursing textbooks it is new to the nation, to the legislators, new to the general public and certainly new to education. It is new to education because until recently preparation for your discipline had only occurred on an in-service basis and in a particular setting.

The difficulty with in-service training is that although you get excellent training here at Pueblo it is aimed primarily at a particular role in a particular place – the Pueblo State Hospital. However, there are some of us in the business who feel that this is not enough. Although we are not sure just how far it can go, we do know that you can make a tremendously larger contribution than you have been making. Many of the people who have authored articles in this book have invested their time and a considerable amount of money, thanks to the National Institute of Mental Health, in exploring new directions to aid each one of you obtain the identity and the proper reimbursement for the knowledge and services that you provide to the individuals and the community. I personnaly believe, and it's the philosophy of our program at Metro, that there is no limit to the kinds of things that you can do. Your work doesn't have to be restricted to a closed ward at the state hospital.

On the other hand, I don't know what you *can* do. Again it is a part of our philosophy and a part of our mission at Metro under a federal grant to experiment with the variety of functions that you might be able to do, and I think you would be amazed at the direction in which it's going. We are training our students in the helping services program at Metro to work not just in a state hospital setting. We are training them to work in a great variety of areas and every day of the week we are introduced to new opportunities.

Very specifically, at this point in our training program, we are bringing people not only into the broad area of psychiatric training, but also training in youth services, in institutions like Lookout Mountain School

for Boys, Mountview School for Girls, Colorado youth centers, and so on. We are training people to work in corrections, retardation, welfare, Head Start programs, education, counselling centers, and special education classes in public schools. Only Wednesday of this week Dr. John L. Lightburn who is president of the psychiatric association in Colorado made the invitation to take a mental health worker in our program into his private practice to associate with him in his office.

Now, this is the kind of direction in which people like yourselves can and will be moving in the future, but only if you want it, only if you work for it. I don't know for sure just how far you can go in what you can do. I wonder if your have any conception of the explosion that is taking place in terms of training people to work not just in an in-service training type setting but in these broad settings. Three years ago, the first program in a college setting with a two year degree began at Purdue. That was number one. The following year, our porgram at Metro began along with programs from seven other places. That meant there were nine programs. Last September there were 16 programs. Next September there will be 57 programs. An explosion is happening. People are getting into this business and hopefully, the manpower needs are going to be met. Our approach, and by "our" I mean all these people who are involved, is that we don't know just how far you can go and we are exploring and experimenting to see just how much we can get in a two year training program; we have no commitment to do things only in a traditional way.

Each of the four schools involved in this national research effort is trying a different kind of program. They are experimenting with different curricula emphasizing a variety of approaches in order to find out what is the best thing we can do in two years to make you the most effective therapists or helping persons.

Our particular program[2] is aiming at four different areas. First, we are training our students to be extremely knowledgeable about all the kinds of institutions in our immediate area. Regardless of the institution they ultimately work in, they know how to pick up the telephone and call somebody at Ridge or at Fort Logan or Larridan Hall or the VA hospital and get immediate information on referrals because they have been there during their training. They are familiar with more than the

organization in which they are working. Second, we are also training them to get out of the institutional setting where they do their immediate work and move out into the community. There they will come into contact with other agencies to learn what kinds of services they provide and how they can work with those community facilities. From this position they can then go out directly in the community and directly into the family home. This is the third target area of our program at Metropolitan State College. This is where the problems are, not in the state hospitals, not in Ridge, not in Larridan Hall. The problems are developed in the home, at work, in the schools; and the mental health worker is going to go to these localities, find out what is going on and work where the problem has occurred. Finally – the fourth specialized thing that we are trying to give our particular people is a relatively new approach to treatment – a knowlege in behavior modification.

No other discipline is training people specifically in this area as their "thing". So the mental health worker or the psychiatric technician, or the mental health technician or whatever he is called in a variety of settings, has to have this "thing" and we feel these four things are something that the mental health worker can bring to the mental health professions. But it doesn't limit him in the kind of thing he can do. We are treating our students to group therapy, to individual therapy and all varieties of traditional services to people with problems. We are doing it in a way that is a little different than the traditional. None of our classes has more than 15 students at a time; this allows open discussion and free exchange of ideas. From the very first week of the fall quarter of next year, our students will be in contact with people with problems. That means that during the entire two years they will have experienced base learning, not just something out of a textbook or something out of my mouth. They will be able to relate what we are doing in the classroom with real people with whom they are having contact.

These are some of the directions in which we are going. Again I encourage you to get hold of this publication of your National Association and find out what other people are doing and where you are going. One thing that I know will be of particular interest to you is finding that a new identity is being recognized. Psychiatric technicians are able to stand on their own feet and not be a sub-discipline working

under someone else's thumb. They are beginning to be respected within their own right. With this respect goes a new understanding for the kind of remuneration that you deserve. You will find through your reading about other programs that salaries are substantially higher in some places than others. Just this week one of the institutions that we are involved with, a federal institution, disclosed to me the salary that it is offering to one of our graduates – a beginning salary of something like $7,300 a year. This gives you some idea of the opportunities that are open to you if you invest yourself in this direction. If you come out of your provincial setting and reach out into the community – recognize your own capabilities and enhance them with additional education – then you can stand side by side with the other professionals. Thank you.

1. "Community Mental Health and the Psychiatric Technician" is a compilation of the presentations made at the 1968 NAPT and California Society of Psychiatric Technicians Convention-Institute in San Francisco. Copies at $1.75 each may be ordered from NAPT Administration Office, 1127 - 11th Street, Sacramento, California 95814.

2. See Appendix I for Curriculum outline.

EDUCATIONAL PANEL
"INNOVATION IN MENTAL HEALTH TRAINING"

by Miss Catherine LaSalle, R.N.
Director Mental Health Program,
Southern Colorado State College

Miss Catherine LaSalle, a native Coloradan, is the director of the mental health program at Southern Colorado State College in Pueblo, Colorado. Before assuming this position in 1968, Miss LaSalle was a registered nurse with the Veterans Administration Hospital for sixteen years.

Her undergraduate training in nursing was obtained at the University of Colorado School of Nursing. This was followed by graduate work at the University of Washington. She is a member of the American Nurses' Association.

The Associate Degree program she describes is unique in that it incorporates licensure requirements for psychiatric technicians with an A.A. program in mental health.

I want you to know that I strongly believe in the concepts that you have heard from both Dr. Austin and Dr. Ingraham. I am very happy for the opportunity to talk to you. In my career so far, I have worked closely with psychiatric technicians, whether or not they were called that by name, and now I am very closely involved in a program that has to do with training, education, and programming for mental health workers.

Southern Colorado State College became involved in education for mental health as recently as 1967. Nationally, much thought and concern is being given to prevent programs from developing that would be dead-end as far as careers are concerned. Educators are trying to program in such a way in the college setting that at the end of two years, the student who has achieved this program can build upon it in a variety of ways. If the student decides to continue beyond the AA degree he should expect his college credits to be transferable. Again at the college setting we are attempting to do this within the two year period.

In both years of our program,[1] we place a great emphasis on the helping process generally. We think that a person who has skills in the helping process can work in almost any setting where there are people in trouble who need help; he can do some specialization later if he wishes. We recognize that institutions and agencies which might hire the product of our educational programs have the responsibility of planning for the best utilization of the student in their own program. They are responsible for helping them adapt to the kind of function which is set out for them to do.

We believe in giving the student plenty of assistance in the helping process from the time he comes into the program until the time that he completes it with an AA degree. We have defined the helping process as those planned and purposeful activities that are carried out by persons in the helping role with another person with the intention of assisting him achieve a more functional use of his inner resources.

The first year of our program is largely concerned with providing the training and skills than an individual would need in an institutional setting. Here he has the role of helping those people who either are so troubled that they had to go to an institution for help, or their community did not have the necessary resources to help them. This first year's main focus is on rather traditional nursing functions. We are involved in helping the helping persons develop skills in supportive activities so that they can become expediters and coordinators and effective members of a psychiatric treatment team.

The second year we have designed specifically to broaden the scope of the student so that he acquire greater understanding of social problems in all kinds of settings. We attempt to increase his sensitivity to the needs of others. We seek to sharpen his skills in the helping process and to develop his resourcefulness and initiative in becoming a worker in his own right in the mental health field. We hit rather hard in the second year three areas that also are included in the first year, but we have purposefully emphasized these three areas because we recognize that the first year puts a great deal of emphasis on the institutional setting and deals with rather extreme forms of behavior. In the second year we put a strong emphasis on family work, on group work, and in working directly with people who need help. From the time he comes into the

program in the second year, we attempt to get him out into areas where he has an opportunity to learn through new and stimulating experiences. Such field experiences are provided by the many community agencies participating in our second year practicum. However, we continue to use the fine facilities at the state hospital during both years of the program. Our purpose is to give the student a broadening which he might have missed in the first year because of the more specific program.

At the end of the first year, the student has earned a certificate in psychiatric technology. He is then eligible to take the state licensing examination in Colorado as a licensed psychiatric technician and be employed immediately in that role. He also has the option of continuing his education as many students do. At the end of the second year, he earns an AA degree in Mental Health Technology. The credits earned in this particular program will satisfy about one half of the science, humanities, and social science requirements for a BA degree.

At this point, there is no BA for a mental health worker at Southern Colorado State College. I don't know what the future holds for that degree, but if the student chooses to go on for a BA, he would have to choose one of the more traditional disciplines such as sociology, anthropology, psychology, or nursing. In these ways we are trying to meet the varying needs of the students in a comprehensive program.

1. See Appendix II for curriculum outline.

THE USE OF OPERANT CONDITIONING TECHNIQUES IN THE HABILITATION OF DISTURBED ADOLESCENT RETARDATES

By Robert G. Thomson
Senior Psychiatric Technician II
Porterville State Hospital
Porterville, California*

Robert Thomson is a Senior Psychiatric Technician II at Porterville State Hospital (California). This is one of the four primary State hospitals providing resident care for the mentally retarded. He is currently assigned to the operant conditioning ward of the hospital.

After graduating from high school in Lindsay, California, Bob Thomson spent four years as a flight engineer on a Navy patrol bomber. He did not immediately become a psychiatric technician after leaving the Navy, but worked in a number of jobs. In 1958 he entered training as a psychiatric technician at Porterville. His experience with the mentally retarded has been extensive and includes work with the severely handicapped, pre-school and school age boys, young adult girls with behavior problems, and severely retarded male adults. The program in operant conditioning which he describes was approved in 1966 by the Department of Health, Education and Welfare under a three year grant.

The project I am going to describe began on June 1, 1966. We chose "Habilitation of Disturbed Adolescent Male Retardates" for two reasons. First, this type of patient makes up less than five per cent of our total hospital population, and there were no programs specifically designed to meet his needs. These boys were scattered throughout the hospital on many wards. The treatment programs on these wards centered around problems that fit the majority of the wards' patients: toilet training, dressing and feeding. Due to a limited staff-to-patient ratio, those boys who were more or less self-sufficient in these areas were pushed into the background. Secondly, these boys either have not learned or have not had the opportunity to learn socially acceptable behavior which would allow them to remain in the community.

The selection criteria for boys entering the program are: (1) they must be in the I.Q. range of forty and over, (2) they must be between the ages of thirteen and twenty-four, (3) they must be relatively free of any organic or physical dysfunction, and (4) they must have some type of noticeable "disturbed" behavior. Disturbed behavior includes destructiveness, lack of motivation, stealing, lying, teasing, temper tantrums, beligerency, aggressiveness and open masturbation.

SELECTION OF STAFF

The choosing of a psychiatric technician staff for the project was done in the following manner. First the senior psychiatric technician II was chosen. A notice was then sent out asking for volunteers. These names were then screened by a panel consisting of the area assistant superintendent of nursing service, the area supervisor, the senior psychiatric technician, and the project psychologist. This screening was done by reviewing their personnel records. Things taken into consideration were past performance reports, which include items such as initiative, quality and quantity of work, relationships with employees, patients and patients' relatives, and a general picture of their entire work record while at the hospital. Other items used in the screening were their class grades, extra schooling on their own time at the local college, and use of sick-time. In cases where there was doubt, they were called in for a personal interview. Their names were then submitted to the hospital medical director, who is also the project director, for his approval before being placed on an eligible list. The panel staffed the ward from this list.

The project is staffed with twenty-two psychiatric technicians and includes the senior psychiatric technician II and a senior psychiatric technician I on each of three shifts. This leaves eighteen psychiatric technicians to implement the treatment program. Of these, nine are in excess of normal staffing of the ward for full patient capacity. The nine additional technicians are paid for out of project funds. Other staff members include the project director, project co-director, the project coordinator who is also the project psychologist, the ward physician, a half-time social worker, a half-time rehabilitation therapist, one and a half teachers and a full-time secretary.

The ward population was lowered from 70-80 to a maximum of 42, consisting of six groups of seven boys each. Each group has a full-time psychiatric technician group leader on each of two shifts with a full-time relief group leader alternating between two groups on the leaders' days-off. The program was set up as an active sixteen hour a day program, covering the morning and afternoon shifts. The night shift staff was not augmented with additional personnel.

USE OF TOKENS AS REWARDS

Our program was designed to shape desirable behavior through rewards, such as praise and extra privileges, small group interaction, and individual counseling by the technician group leader. For undesirable behavior all rewards are withheld, theoretically making it more profitable to the boys to exhibit more socially acceptable behavior. It was discovered that the boys soon became bored with constant social approval; even candy soon lost its appeal for some. Special events and extra privileges might be a day or two in the future, therefore using these as an immediate reward had little value. This brought about a change in the program. It was then decided to use a token economy system.

Tokens have many advantages. They can be carried by the technician and given to the patient immediately when any acceptable behavior is exhibited, thereby satisfying the need for immediate reinforcement. Tokens can be traded for a variety of items and privileges. In this way the boys are given a choice to decide what the reward might be. One boy might spend tokens to attend a movie while another is saving to rent a private room. This gives them the opportunity to make decisions and plan activities according to their own desires, rather than passively conforming to ward routines and staff decisions. This tends to make them more independent and responsible. Tokens also give the boys an excellent opportunity to learn the skills of handling money.

PROGRAMS TO TEACH SOCIAL SKILLS

Our program is so designed that the boys' everyday experiences can be used as teaching and learning experiences. It emphasizes teaching of new skills and the control and reduction of inappropriate behavior. This

is done in many ways and settings; the token economy weaves itself into all of them.

The first group of learning experiences occur at *ward level.*

1. Individual Programs — Each boy has set up, depending on his individual behavior problem, or need, a personal program. A personal program might be directed to control "cursing when corrected or teasing other patients". He would be paid tokens for showing control when corrected, or for demonstrating appropriate interactions. In special cases he might be given a set amount of tokens at the beginning, and each time he curses when he is corrected, or when he teases others, he would forfeit a portion of them.

2. Ward and Kitchen Chores — Once each six days a group will be assigned ward chores. This means cleaning all areas other than sleeping areas, the kitchen and dining room. Each group is responsible for its own sleeping area; the kitchen and dining room is a separate assignment. The group leader provides counseling and guidance in these areas to make sure the boys know how to do the chores properly. When a boy is ready to return to his own home, or a foster home, he will be expected to do such work.

3. Special Privileges — There are movies and dances at the hospital on a weekly basis. If the boy has behaved appropriately for two days prior to, and on the day of these activities, he is eligible to attend, if he has tokens to pay for these privileges. At ward level, we also have a store that is stocked with candy, toilet articles, model kits, watches, radios, electric razors and numerous other items. The boys may request new items to be stocked at the store.

4. Counseling — Another ward level experience is provided through counseling sessions with group leaders. Each time outstanding behavior is exhibited, either appropriate or inappropriate, the boy's group leader talks with him. If his behavior is appropriate, he receives rewards of praise and/or tokens. If it is inappropriate, he is told what he did wrong and how to correct it. If the behavior is habitually inappropriate, an attempt is made to substitute a more

acceptable bahavior for it. The group leader also has group sessions with his boys to discuss each others problems. Peer pressure often helps a boy change his behavior patterns.

Another area of learning experience is through *School and Rehabilitation.* All boys attend school, usually from one to two hours daily. They receive daily grades based not on class averages, but on their individual capabilities and motivations. The group leader attends school with the boys and monitors their behavior. Bonus points are given if there are no disturbances and no cheating. All grade points are tallied and are converted to tokens when the boys return to the ward. Each boy must take a grade slip with him to school. He is also required to write his name and date on it or no tokens are given. At school the boys are not confined to academic work only. They do ceramic work on a contingency basis; that is, academic work must be completed before ceramics can be started. They are also exposed to the school farm where many varieties of flowers and vegetables are grown. There are also many animals and fowl, the largest being a small burro. This is very worthwhile as some of our boys have a history of cruelty to animals; this gives them a chance to learn better behavior.

At Rehabilitation there are four areas of teaching, and they are on a promotional basis. Here it is not confined to our half-time therapist. The entire Rehab staff is utilized. The first stage is *Rehabilitative Intensive Therapy.* Here the boys are taught some basic finger and hand skills by doing model work and working with mosaic tile kits, but primarily they learn the proper way to function in a small group. From here, or in conjunction with it, the boys can go into an *Industrial Therapy* assignment. Here they learn such basic work skills as sweeping, mopping and bed making. This is also the first step in teaching them to get along with future employers. They might be assigned as ward aides to assist technicians with ward housekeeping, or as truck aides to help pick up and deliver laundry supplies, food carts and trash. Here again they must take a grade slip with them to their assignment. On their return to the ward, they are paid tokens contingent on quality of work, punctuality, initiative and motivation. From an Industrial Therapy assignment a boy can be promoted to the *Vocational Workshop.* The workshop has many contracts for souvenir ceramic work, printing jobs, and small hand work for several manufacturing concerns. They also

design, silk screen, and sell Christmas cards. The profits from these are used in three ways. First, as salary for the patients involved. Secondly, a portion goes into the general patients' benefit fund which is used for all patients in the hospital, and finally, a portion goes into the Vocational Rehabilitation Fund. This is used to take the patients on work connected or recreational field trips.

From the workshop the boys are promoted to *Skilled Training Assignments* within the hospital. They may work as janitors, aides, storeroom assistants, mechanics' helpers, landscape gardeners' assistants, and baker or cook's helpers. These boys are actually considered employees and their supervisor acts as their employer. They are paid a salary, usually on a weekly basis or, if more immediate motivation is needed, on a daily basis. These boys are then placed on work assignments in the community, usually in jobs similar to positions they held in skill-training. Many are placed in gas stations, garages, paint and body shops, car washes, restaurants, and bakeries. They are usually taken to work on a commuting basis from the hospital. Many boys, after they have mastered appropriate occupational and social skills, including handling money, are placed in their own home or in family care homes and work in the community. Some even live on their own either in a hotel or apartment.

The last area of training is through *Community Activities.* They are taken on shopping trips and the boys are supposed to make the actual transaction. These trips are earned by exchanging tokens for currency on a three-to-one ratio. In other words, one hundred tokens are equal to three dollars. Incidentally, this same ratio is used in our ward store. The boys' earning power, with very good behavior, good school marks and an industrial therapy assignment, is approximately seventy tokens daily. The boys go on cookouts, over-night campouts to the mountains or desert, fishing trips, snow trips, community movies and many other community activities. This enables the group leader to teach the boys what type of behavior is acceptable for community living. The boys have also attended major league baseball games, football and basketball games, and have taken many educational trips. To participate in these activities the boys must meet certain standards of behavior and must pay for the privilege with tokens. If their behavior is acceptable while on these trips, a portion of the charge is refunded to them.

NEGATIVE REINFORCEMENTS FOR INAPPROPRIATE BEHAVIOR

The treatment within our program is primarily one of positive reinforcement, however we do use some negative reinforcements. A system of fines is set up for specific offenses. All fines carry the same weight of fifteen tokens; however, they are divided into two categories, major and minor. Major offenses include: possession of matches or other fire making equipment (one boy discovered that by using a transistor radio battery and steel wool spread out that he could make a very good cigarette lighter), fighting, stealing, unacceptable behavior which requires that he return to the ward from off-ward activities, and abusing property, either state or private. Minor offenses include: swearing, smoking in prohibited area (this also includes smoking if they are underage), lying, returning late to the ward from ground privileges, making a disturbence after bedtime, indulging in excessive horseplay and teasing other patients. Minor offenses call for a fine of tokens only, while major offenses call for a fine plus a deprivation.

Deprivations include ineligibility to attend a dance, movie, or any off-grounds trip, withdrawal of store privileges, or, if the offense is a serious one, loss of ground privilege card for up to twenty-three hours, or longer, if the ward physician orders it. Another major deprivation would be removal from the group to an unlocked side room for specified period of time, usually fifteen minutes to an hour depending on whether he stays in the room and creates no disturbance. For very serious offenses such as elopement, locked seclusion in a side room for a short period may be used with a physician's order. At the beginning of the program, this was automatically two weeks in seclusion. This was lowered to two days in seclusion with the ward locked two days for all boys, in the hope that this would bring peer pressure to bear on the offender.

Statistics showed that seclusion, whether short or long, had very little if any bearing on the rate of elopements. We now use only restriction to the ward until the boy earns his ground privilege card back. This takes a minimum of ten days. In all cases, the levying of a fine calls for an immediate counseling session with the group leader who will explain why the fine was levied and how to avoid future fines.

DECISION MAKING AND COMMUNICATION

Decision making and sharing of information within the program are carried out in four levels. (1) Numerous *informal meetings* with the program coordinator, the senior psychiatric technicians and individual groups leaders, to discuss minor problems involving adjustments to individual programs, details of the token economy, clinical aspects of problems and the hundred and one little problems that the patients present every day. (2) Weekly *program development meetings* attended by the ward nursing staff on duty, those on the afternoon shift that can come in early, and the project psychologist. The purpose of these meetings is to share information by the project coordinator on results of previous meetings. Weaknesses and suggested changes to the program are also discussed. These meetings also provide for a general gripe session for the technicians. Many employees hesitate to speak out when the supervisors above ward level and other divisions are present. (3) Weekly *ward team meetings*, attended by the ward physician as team leader, the chief psychologist, the project psychologist, ward social worker, the school teachers, the rehabilitation representatives, the area assistant superintendent of nursing service, the area supervisor, and all ward staff able to attend. The hospital chaplain also attends many meetings. The primary purpose of these meetings is to discuss progress or lack of progress in individual boys. Each boy is discussed at least once every three months and more often if necessary. The group leader gives a progress report followed by a report from school, rehabilitation and social services. These are discussed by all members present and recommendations are made in regards to changes in treatment programs, referrals to vocational rehabilitation, family care, return to the boy's own home and in many cases continuance of the present program. The ward team also discusses major problems within the program and any major change recommended by the program development meetings. (4) Major changes are then passed on to the final decision-making authority, the program director. He can either approve, disapprove or modify any recommendations from the ward team.

One major change which was recently approved and initiated, started at the lowest level and progressed up through all levels with changes made at each of them. This was a change from the six group concept to a three level, six group concept. The levels are junior, intermediate, and

senior levels. Each level has more privileges than the one preceding it. At each higher level the cost of privileges or goods decreases, and in many instances are free for the senior group. This gives the boys an immediate reward for promotion. At this level we are trying to wean the boys away from needing the crutch of tokens in preparation for their return to the community.

It was felt that this system would give the boys a more foreseeable goal to work for, because the promise of referral to vocational rehab or skill training, especially for the younger boys, could be months or even years away. The reason for this is that Vocational Rehab starts at age sixteen. Promotion within these three levels are governed by the amount of fines, loss of bonus points at school and how many times a boy has been returned to the ward for unacceptable behavior from off-ward activities. The time element for promotion is two weeks from the junior to the intermediate and a month from the intermediate to the senior. The boys must maintain set standards to remain in the intermediate and senior levels, otherwise they will be demoted one level.

SUMMARY OF RESULTS

To summarize the project's successes and failures since the beginning to April 1, 1968, seventy-one boys have entered the program. Of these, twenty-two have been referred for placement back into the community. Two-third of these have been placed and the balance are awaiting administrative action. Seven boys have received maximum benefit from the program and have been transferred to the hospital co-ed ward as promotions. Only three have failed to respond and were transferred back to their home wards.

IMPLICATIONS OF OPERANT CONDITIONING FOR PSYCHIATRIC TECHNICIANS

I would like to discuss briefly the implications of operant conditioning for the psychiatric technician. First I think it gives the technician more job satisfaction in that he can see actual progress being made in patients, primarily because he is looking for it rather than just accepting it. This means that he must become more patient-oriented rather than job-oriented because he is working directly with the problems that

caused admission to the hospital. Too often on other wards, job-oriented behavior is encouraged because the supervisors tend to look for clean and neat wards and patients and overlook items that don't readily show, such as fewer fights or better behavior in a majority of patients. The technician is given much more freedom and responsibility to use his initiative in working with his patients. His suggestions and ideas are carefully considered and many times implemented by his superiors and fellow workers, and he gets credit for them. This proves that operant conditioning works as well on staff members as it does on the patients. The staff on our program feel that they are a part of it and not just another employee to do "what they are told" by their immediate supervisor. Our staff is very outspoken and many times in our meetings I have been the target of verbal complaints (usually justified) of interferring in the groups. After years of working directly with patients, it is very difficult to say "go see your group leader" when a boy asks you to do some simple thing that would only take seconds to do. This however is something that has to be done; otherwise you destroy the leader's effectiveness. The boys learn very fast that they can get something from another technician that they possibly could not get from their group leader.

The technician must also be able to take a very close look at himself. When he fails to reach a boy, he should ask himself, "What am I doing wrong that I can't reach him," and not, "Why can't he grasp what I am trying to give him." Most children tend to emulate their elders; therefore the technician must monitor his own behavior before attempting to monitor the behavior of others. How can you expect a boy to control his temper when you cannot control your own? How can you criticize him for lounging with his feet on the furniture when he sees you or others doing it?

One major item which shows the job satisfaction that our staff receives is the turnover rate. We have only filled nine staff vacancies since the beginning of the program. Four of these were because of promotions, and two left state service. Only three were due to dissatisfaction or inability to function within the program. A program of this complexity depends very much on the cooperation and attitude of the ward personnel. The low turnover rate indicates that we have earned the support of the staff.

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IMPLICATIONS OF USING OPERANT CONDITIONING

By Dr. Kent Kilburn

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Kent Kilburn received his Doctorate in Education in the field of educational psychology from Utah State University in 1964. His predoctoral educational interests were directed toward criminology and specifically toward corrections. He has maintained this interest in addition to his heavy workload at the hospital and as a counselor and consultant in behavior evaluation and therapy. He is also Assistant Professor of Criminology at Fresno State College.

His publications have been mainly on educational and psychological testing of the mentally retarded, speech disorders and reinforcement theory. He is working on papers on predicting success of psychiatric technician trainees in training programs; attitudes toward theories of juvenile delinquency, and toward mental retardation. Dr. Kilburn has made presentations on token economy systems to various psychological associations.

In very recent years, the use of operant conditioning principles in hospitals for the mentally ill and retarded has become widespread. A review last year indicated at least 51 "token economy" programs (which is one form of applied operant conditioning) current in the United States and Canada. This popularity, however, is accompanied by considerable controversy. Having been developed primarily through experimentation with animals, some critics question the validity of generalizing results of the behavior in humans. It has also been said that the medical model has been threatened because important aspects of treatment are now done by non-medical persons. Some people label operant conditioning with such terms as "mindless", "mechanical" and "simpleminded." There has also been some "static" within our own ranks claiming that the usefulness and scope of operant conditioning

has been overstated. This controversy does provide a stabilizing influence and, hopefully, leads to a more uniform growth in the developing theory.

In programs utilizing operant conditions, primary emphasis is placed on the development of acceptable functional behavior with secondary emphasis on the reduction of inappropriate behavior. Contrary to many current opinions, operant conditioning programs *do* aim to develop individuals to their fullest potential but these programs are not hung up on the mere eradication of temper tantrums, stealing, and aggression. Programs with these goals emphasize the use of positive reinforcement; they are primarily reward systems to develop acceptable functional behavior. Inappropriate behavior is weakened or disrupted by negative reinforcement, usually extinction procedures, such as short term isolation, often referred to as "time out from reinforcement," or deprivation from a minor privilege. These priorities in emphasis are determined largely by our better understanding of the effects of positive reinforcement, the potential for abuse that exists where punishment is involved, and the emotional reactions from citizens and professionals when negative reinforcement is used. I would like to call your attention to Dr. Menninger's recent book, *The Crime of Punishment,* which deals with the question of punishment from a dynamic as well as behavioristic standpoint. In those programs where punishment is used, the ensuing controversies usually give little heed to the extensive use of programmed reward systems for appropriate behavior. Some abuses have occurred, of course, and reasonable guidelines and safeguards established by experts in the field will eventually be established.

Positive reinforcements are made available to patients by allowing them to manipulate their environment through acceptable functional behavior. In most cases, rewards can be earned by a wide variety of appropriate behavior. Except for training in various specific types of tasks, the patient or resident is free to choose within behavioral categories, those behavior patterns which will lead to rewards. This is contrary to the popular notion that patients are forced to behave in mechanical meaningless ways for a tidbit of food or a token. Inappropriate behavior does not yield rewards and can lead to mild negative consequences.

The general idea behind operant conditioning is that acceptable behavior which is consistently and systematically reinforced, will become ever-stronger and will slowly push out or overwhelm inappropriate behavior which is no longer profitable.

The precision and specifics that operant conditioning demands, is one important difference between this type of program and more general programs of milieu therapies or therapeutic communities. In this type of program the psychiatric technician plays a key role. In our facility in Porterville there are over 800 psychiatric technicians to take care of 2,450 residents. There are five psychologists and four students assigned to the program. Nine of us could not watch very many patients very long even if we worked 120 hours a week, so we rely quite completely on the psychiatric technician to monitor the residents' behavior and to effect behavioral changes. As psychologists we serve primarily as consultants to the program's problems rather than as "do-ers" of the program itself. This doesn't mean that the psychologist is not involved in direct contact with the resident, but it is obvious that such contacts must be limited.

The behavior patterns of the patients indicate many areas of deficits or immaturity. They have not learned necessary social habits, or the habits they do use are no longer appropriate to their age level. Given these postulated antecedent conditions it is apparent that an adequate program must provide a setting in which a great deal of social learning can be accomplished.

The function of operant conditioning is to provide a motivation system or a consistent set of consequences that are essential to learning. The physical setting elicits some behavior. Encouragement and guidance by group leaders elicit other behavior, but the development and maintenance of *new* behavior is the primary focus of operant conditioning.

In the Porterville program the staff was trained in the use of rewards. The training program emphasized immediacy, consistency, contingency, schedules of reinforcement, and the appropriate use of such rewards. Negative consequences were identified as verbal disapproval or reprimands, deprivation of privileges and short term isolation. While staff training involved the use of negative reinforcement, the staff were also

told why positive reinforcement was to be emphasized. Application of negative reinforcement was set up as a two-stage process. Every time a deprivation or reprimand was used, the group leader had to point out to the patient the inappropriatness of the behavior and, more important, how the patient should behave in the future under similar circumstances. In this way a new behavior, or "operant", was suggested to the patient and would be rewarded if he chose to use that suggestion. This particular plan was necessary because one familiar effect of negative reinforcement is temporary suppression of behavior. An alternative competing response must be operant to the resident if a long lasting change is to occur.

These principles were employed in two major types of programs. The *first* type was a specific program for each patient that dealt directly with his particular behavior problem. Attempts were made to remove any rewards that were sustaining inappropriate behavior. More mature types of operants were established along with a feasible reward system. As an example, one patient was extremely resistant to involving himself in any social activity. He was slipping into long periods of depression and was combative if he had to do anything other than minimum basic tasks. It was noted that in his better moments, he liked to be a helper for his group leader. He was asked to attend a movie as an assistant to the group leader to help supervise other patients. With some urging, he did this and was praised by many of the staff. He did this on a number of occasions and soon began to enjoy the movies as well. At this point, external rewards were slowly diminished and the same technique was used to get him to go to the swimming pool. Swimming soon turned out to be fun. The assistant role was eventually dropped. Once he became more active, other patients befriended him, thereby creating another source of intrinsic reward. The patient's social life expanded and his periods of depression became less frequent and shorter in duration. He is now in a skill-training assignment that would prepare him for employment outside the hospital. The reason for his depressions are not understood, but the onset is readily detectable within hours and intense social involvement usually prevents any further withdrawal.

Programs are worked out jointly with the group leaders, Mr. Thomson who is in charge of the ward, and the project psychologist. All unusual

programs are approved by the project physician or the entire ward team; the group leader is then responsible for applying these programs on a day-to-day basis.

The *second* type of program deals with the development of basic self-care skills in which retarded patients are usually deficient. For this group, skills such as grooming, choosing appropriate dress, personal hygiene, and responsibility for routine chores are taught in the daily program. Along with standard training techniques, rewards are applied to maintain and develop behavior.

After nine months of operation, it became apparent to us that the use of naturally occurring rewards has serious limitations. First of all, use of natural rewards results in a shortage of rewards. Social reinforcement swiftly becomes ineffective if it is used repeatedly in a short period. Candies and treats are most effective, but must be available in large quantities. Privileges are also in short supply considering the demand for them. Secondly, the limited availability reduces the scope of target behavior that can be treated by these principles. This interferes with the simultaneous programming of various facets of behavior. A third weakness is that many of these rewards cannot be made immediately contingent on appropriate behavior, (one of the very basic requirements of operant conditiong). The last major limitation is that individual differences with regard to rewards is difficult to take into account. A reward must be attractive to the resident if it is to be effective, but, as with most of us, preferences change from day to day and we like to be able to choose our own diversions. If these differences cannot be taken into account, the rewards become less effective.

These limitations in the existing reward system led directly to the adoption of the token system of rewards. In a token system metal coins are used as rewards. Patients then redeem their tokens for a variety of privileges, material goods, and special events. Negative consequences then become fines for which a standardized list of offenses and fines have been drawn up.

This system is superior in many ways. Consider these points. There is no shortage of tokens in our system because a patient may earn up to 45 or so a day. More target behavior can be considered for each patient.

Tokens can be given immediately, thereby satisfying the rule for immediacy. The variety of goods for which tokens may be redeemable allows individual differences to be taken into account. The patient is allowed and encouraged to spend his tokens as he desires. He is not told what is good for him. In this way, he not only manipulates the environment to earn tokens, but he also manipulates it in terms of choosing his own activities.

In our program, tokens are used to reward behavior in the two types of programs previously described. In addition, industrial therapy assignments earn tokens if adequately performed. In the school program, teachers give points throughout the session for achievement and good behavior. Points are converted into tokens at the end of the class session. This allows the teacher greater flexibility in rewarding even small gains that previously might have been ignored.

The goods that tokens may buy are the foundation of the token economy system. The availability and control of goods and privileges determine the reinforcing properties of the tokens. It is the group leader's responsibility to adjust the token program to the individual patient so that active participation is always within the patient's grasp. In addition, he must gradually increase the demands on the patient to encourage greater behavior growth. The same principle applies to participation in the whole program. As his capabilities increase, commensurate responsibilities are given the patient and he is promoted to a more complex program.

Recently, it became apparent that the repertoire of material of social reinforcements was not sufficient in itself to promote and maintain active participation by all of the boys in the program. A so-called "hard-core" group seemed unable to do more than secure ground privileges and barely stay in school. It was also apparent that other patients who were progressing well through promotions in the program were still overly dependent on token transactions. As a result, the six groups of patients were organized into three levels of social competence with promotion to the next higher group based on evidence of socially acceptable behavior and the relative absence of fines and misbehaviors. The two higher level groups were allowed more non-contingent reinforcement and also the right to participate in such off-ward

activities as the hospital's vocational training program. In this way the new patient could be shown a step by step procedure by which he could progress from admission to community placement. As he progresses in the program, there is a gradual change from extensive immediate and continuous schedule for monitoring and reinforcing desired behavior, to an intrinsic delight and intermittent schedule of monitoring and reinforcing behavior. Thus, the sheltered-ward environment of the token economy comes to approximate the environment of the community.

The problems that do develop in techniques of administering positive and negative reinforcements are often practical ones and it is easy to take a practical approach rather than a theoretical one to find a solution. In spite of staff training, traditional approaches continue to be used. For instance, if fines do not appear to be curbing a problem, a frequent reaction is to suggest an increase in the fines. The theoretical approach investigates the consequences and asks what positive behavior is being developed to replace the undesirable ones. In some "practical" approaches it is easier for the ward staff to over-react to a situation by increasing security and penalties, or to rely on a negative approach stemming from an attitude of "teaching the patients a lesson", than it is to show them a better way to behave. Of course, the negative approach is more rewarding to the staff because effects are usually immediate and dramatic. Unfortunately, supression of behavior is effective only while the punishing agents are present. The positive approach usually takes longer to produce an effect; however, the effect is more likely to be sustained in a variety of situations.

In applying any new treatment approach, there is always the problem of breaking down old attitudes and beliefs that are inconsistent with the new method. It appears that operant conditioning, too, has its share of such difficulties, possibly because, in many respects, it is in sharp contrast with traditional methods. The notion of allowing patients to make major decisions concerning their activities is contrary to the dependency we usually instill in patients and it is an "inefficient" way to handle patients. Many people resist the idea that the staff and their practices might be contributing to the maintenance of behavior problems. Theoretically, the applications of operant conditioning principles should not be more difficult with one population group than

with another. However, social implications for varied patients groups differ. There are more problems associated with attempts to modify socially complex behavior patterns.

This consideration leads directly into the difficulties involved in insuring that social training would generalize to other than ward situations. This is probably the most critical problem with operant conditioning practitioners. While operant conditioning can train patients to behave adequately on a ward, it does not automatically guarantee that the behavior will continue in the community.

According to learning theory, response generalization is facilitated when stimuli is similar to the training stimuli, an adequate reinforcement system is present, and the behavior is quite stable. With simple self-help skills, these conditions are easily met, but with more complex social skills that are affected by more variables, the task is difficult. It is possible to create a home-like atmosphere on the ward in terms of physical surroundings, but as in the case of our program with 42 residents and 22 psychiatric technicians, the psychological climate would certainly not be the same as at home. The demands of parents in their reinforcement systems are likely to be very dissimilar to those on a ward.

Despite these limitations, some solutions are available. For example, a token economy program with retarded girls at Pacific State Hospital in California elicits the cooperation of parents by meeting with them regularly, describing each patient's program, and teaching the parents how to extend the program into the home. At Parson's State Hospital in Kansas, Dr. James Lant has a middle-class Kansas home built right onto the ward; it has a kitchen, dining room and living room available as training sites. In our program, we have the patients participating in large number of community events and encourage home visits at appropriate times.

The implications of these problems is that programs must be extended beyond the ward and into the environment to which the patient returns. But in California this is a bit rough because when patients are in the hospital, they are under the jurisdiction of the Department of Mental Hygiene. They leave on a definite leave, and at any point, until

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they are discharged, they are under the jurisdiction of the Department of Social Welfare; actual coordination goes clear up to Sacramento and one step below the governor. I don't know how the pie got divided up in that strange manner, but it doesn't make for very much continuity.

In conclusion, I would like to emphasize that operant conditioning offers a body of knowledge that can be applied to a wide variety of hospitals and community populations. With disturbed retardates, it has allowed us to develop a motivational system that is not only congruent with antecedent social conditions but also congruent with many aspects of enlightened hospital care. The principles and techniques can be taught to ward level personnel, thereby placing potent treatment methods in the hands of those in daily contact with the patients. While controversies and limitations do exist, I do not believe that operant conditioning is a fad that will run its course in three or four years and gradually disappear. The current literature indicates sophistication and expansion with an appreciation of inherent difficulties. In the hands of responsible people, I can see operant conditioning maintaining a respectable position in our repertoire of treatment techniques.

For further specific information on operant conditioning and particularily token economy systems, I would recommend to your attention three recent publications: Ferster, C. B. and Parrot's text called *Behavior Principles*; Ayllon, T. and Azrin, N.H., *The Token Economy – A Motivational System for Therapy and Rehabilitation;* and Shaefer, H. H. and Martin, P. L., *Behavioral Therapy*. There is also a monogram from the California Department of Mental Hygiene by Dr. Thomas S. Ball on the establishment and administration of operant conditioning programs in a state hospital for the retarded.

It is a real privilege to be here and talk with this group. I would like to reemphasize the fact that if the mental health battle is to be won, it will obviously be won through the efforts of the professional people who deal directly with the clients. I certainly do appreciate the opportunity to meet with the group that I consider number one in winning the battle in mental health.

THE CULTURES AND PSYCHIATRY

By Sidney G. Margolin, M.D.

Dr. Sydney G. Margolin is Professor of Psychiatry at the University of Colorado School of Medicine, where he is also Director of the Human Behavior Clinic and the Ute Indian Project.

After receiving his Master of Arts and Bachelor of Science degrees at Columbia University. Dr. Margolin completed his work for his Doctor of Medicine degree at New York State University of Medicine.

Before affiliating with the University of Colorado, Dr. Margolin taught in New York, at Columbia University and at the New York Psychoanalytic Institute. He is currently also giving service as a consultant at the Colorado State Hospital at Pueblo.

Very active also in the field of Research and Publications, he has done work in the fields of Psychoanalysis, Psychotherapy, Psychosomatic Medicine, Psychophysiology, Biophysics, Bioengineering, Ethnopsychiatry, and Medical Education.

Usually when we say that somebody is "disadvantaged", we mean that he is socially disadvantaged, economically disadvantaged, and that he is also culturally disadvantaged. Usually, we mean by that he is comparatively inadequate or had insufficient educational opportunities, and therefore, educational achievement.

Who are these "disadvantaged" people? Well, to begin, we usually hit a term, "minority groups". Then you begin to hear a lot of color schemes. They are called black people, brown people, red people, white people, and now those who admit the facts of life are recognizing mixture of colors. So we begin to hear about gray people, tan people and olive people. In short, we hear a lot of colors which really are not true. No one is any of these colors. I have yet to see anyone who is truly black, truly white, truly red, or truly brown unless he has a very serious sickness. The probability is therefore, that these colors have an elaborate emotional meaning and intention which those of you who would think about this might understand. These are also referred to as

the minority groups. If you were to add up these minority groups and include the disadvantaged white people, whatever color they are, you have the *majority* population. This is the important issue.

We usually compare these disadvantaged people with the dominant group, the so-called advantaged group. The disadvantaged people who have to be compared with advantaged people obviously are not accepted by each other or do accept each other. There is a boundary between them of various kinds. Do the advantaged and disadvantaged have difference in their mental health, their psychiatric diseases, and in the psychiatric treatment they get? Can we describe the advantaged and disadvantaged people in terms of mental health treatment and so forth? Of course, this depends a great deal on what we mean by mental health and treatment of mental disease.

Let us begin with a fact that I think may surprise you. Namely that the definition of mental health, and the classification of mental disease, and the treatment of mental disease, have all been set up by the advantaged group. What we say about the patients does not take into account that their ethnic origin, their socioeconomic circumstances may actually influence the kind of disease they have or the way the disease is to be described or understood. So that the disadvantaged and the multi-ethnic groups that we are talking about are at a medical disadvantage because methods of classifying them and understanding them are not derived from an actual study of them.

Let's start with a statement about mental health. We do not have a scientific definition of mental health, that makes any sense, which can be used for the prevention of mental illness in the advantaged and disadvantaged. In fact, if we apply the definition of mental health viewed by the advantaged, we find out that we require social and economic cultural resources that simply are not there to the disadvantaged. That is, if you tell a family how to rear a healthy family, you are immediately talking educational facilities, certain economic advantages, certain availability of health resources, and so forth, which the disadvantaged simply do not have. Consequently, any definition based upon the proper rearing of children simply would not apply to the disadvantaged.

For example, we certainly would say that it is good for a family to have an economically secure family organization. We certainly want to recommend certain types of educational facilities. We certainly would want to recommend that health resources of all sorts be available and, of course, we would like to recommend the non-ghetto type of social organization. All of these are not available to the disadvantaged. As a result the disadvantaged have been obliged to develop their own systems of the causes and nature of mental illness. For example, the Spanish-speaking people have a very elaborate system of causality; the Indian population have an equally elaborate system of causality. A certain percentage of the black population have a system of causality that might be based on a mixture of the Hispano and the Indian. And of course, the disadvantaged white people have a system of causality based upon sin, guilt, and perhaps a mixture of magic, witchcraft and all the other so-called non-scientific causes of disease.

Let me say that although the Indian, the Mexican, black, the disadvantaged white have these remarkable theories and practices of disease and treatment, we cannot say that these are ridiculous systems or ridiculous methods of treatment. If you do, then all you are doing is applying the advantaged point of view. Statistics show that the Hispano by means of a *curandero,* and the Indian by means of a medicine man find their treatment about as effective as the so-called advantaged theory and practice. I don't have statistics, so you can challenge me on that if you would like. I think, though, we could make a good case for it.

What is significant in this for the psychiatric technician? Let me say a few things about the psychiatric technician which I think are basic. He is a key individual in the diagnosis and management of mental illness in the disadvantaged. I have to say that again – the psychiatric technician is a key person in the diagnosis and treatment of the disadvantaged and I will explain why that is so. The psychiatric technician can speed up the education and improve the skills of the advantaged psychiatrist and administrators and here I speak of long personal experience. I have learned a lot. The nature of premedical standards of education have a built-in way of excluding the disadvantaged. Disadvantaged people cannot become psychiatrists, except by some special dispensation. The reason for that is very simple. They do not go to the school that will

give them the kind of education that permits them to make high scores on the aptitude tests or permits them to meet the standards of an ever-aspiring admissions committee of a medical faculty.

Because of this problem, I am glad to tell you that at an executive faculty meeting at the University School of Medicine recently the entire faculty unanimously made the following resolution which will be put into effect shortly. Namely, that the number of students that can be admitted to the school be increased by ten and that these students should only come from the disadvantaged groups. Furthermore, the admission group was to be instructed to modify their standards to admit these students. Finally, the resolution called upon the faculty and the students of the medical school to provide tutoring, supporting, and general assistance services while these disadvantaged students are in medical school, in order to bring them up to the standards of the school. As far as I know, it is the first such step taken by a medical school faculty on its own. It will be circulated throughout the country and other schools will be encouraged to follow suit.

Now again, what has this to do with the psychiatric technician? Let's face it. As far as I can find out, the typical background, and I am sure many of you will find exceptions to what I am about to say, but I'm speaking from the statistical average, the typical background of the psychiatric technician does not contain the social, economic, and educational opportunities of the advantaged. The chances are if they did, they would not become psychiatric technicians. They might have become college graduates and assume the professional activities that are available to them as college graduates. As a result the psychiatric technician tends to come somewhere between the disadvantaged and the marginally advantaged. This means that the psychiatric technician, from his own more of less disadvantaged background, knows the people, their values, and how they think and feel. In addition to this knowledge of the disadvantaged, he, as technician, has also learned the points of view of the advantaged. So we have in the psychiatric technician an individual who knows the special values and means of communication of two socioeconomic groups. The psychiatrist, by and large, only knows his own special values; our society tends to be middle class and upper class – the advantaged. The psychiatrist in classifying disease cannot rely upon his traditional education and training for the

I can illustrate this by a set of experiences that I have had with the group at the State hospital here in Pueblo. We have been talking with patients from Spanish background and very often the interviews were conducted in Spanish. From our interviews we determined that many of these patients were not psychotic, but rather victims of witchcraft. Now, when you are bewitched, you explain certain things happening by themselves. The happenings have an inner power and an inner authority which in the Anglo-white psychiatric system means delusion and hallucinations; if you are delusioned and hallucinate, you have a couple of points in favor of the diagnosis of the psychosis. But it turns out that many of these patients with these experiences are commonplace in their culture. Their experiences and behavior were considered as expressions of a disease which is deviant of that culture, or is deviant even within the Anlgo-white system of psychiatry. This group very fortunately was able to make the situation clear to me after overcoming some of the initial problems we had in attempting to understand each other. This is where the understanding of the psychiatric technician is invaluable in explaining the patient to the psychiatrist.

There is, however, a danger that the technician may over-identify with the patient. He may become so defensive of the patient's point of view that he fails to recognize the level of real pathology. For example, one of the patients presented to me was an individual whose illness was obviously expressed in terms of witchcraft. This would of course be diagnosed as delusional at various levels and the patient would be considered psychotic. After going into it, it turned out this was an expression of the culture and background of their particular patient. But the technicians, in their need to defend the patient's illness and his culture, rather than psychopathology, overlooked the fact that he had an organic brain syndrome which was demonstrable by methods independent of the cultural factor. After this was brought out, the Anglo-white psychiatrist and the psychiatric technician together presented a very realistic and valuable picture of the patient.

The psychiatric technician and the psychiatrist must help each other to overcome the tendencies that are built-in to support the point of view

of the advantaged and the disadvantaged. It is not a one-way street anymore. It is more than likely that the psychiatric technician is better informed about these problems, but more inclined to keep his information to himself because he does not want to challenge the existing power situation. But there are changes going on in the academic and medical world today. It is less and less true that one cannot start a conflict. We see successful demands that the curriculum of our schools and professional education be changed to cope with special circumstances of the disadvantaged.

To have a knowledge of the diverse backgrounds of all types of peoples means that we have the information that is essential in the diagnosis and treatment of mental disease and without this knowledge, we will never increase our ability to prevent mental disease. In this concept, the psychiatric technician is a key person.

A COMMUNITY PROBLEM: THE NEED FOR SPECIALIZED GROUP HOMES

By Evelyn Todd

Evelyn Todd is a licensed psychiatric technician. She began her career in mental health in 1962 when she enrolled in the basic nine-month course for psychiatric technicians at Colorado State Hospital. After completing this training, she worked as a psychiatric technician for two years in the geriatrics center of the hospital.

From geriatrics she went to work with emotionally disturbed pre-adolescent boys in Children's Treatment of Colorado State Hospital. She completed the advanced training program at the hospital which qualified her to work as a Senior Child Care Worker. She continued her education and enrolled in the A. A. degree program for Mental Health Technicians at Southern Colorado State College and received her degree in June, 1969.

She is currently employed as a Principal Psychiatric Technician with the newly organized Short-term Treatment Crisis Team. This team is a part of Children's Treatment Center and a component of Southern Colorado Mental Health Center.

INTRODUCTION

The lack of small specialized group homes in the immediate vicinity of residential treatment centers is one of many existing community problems in mental health.

It is the purpose of this paper to show: 1) the urgent need for more community centered specialized group homes for emotionally disturbed children who are discharged from treatment facilities back into the community; 2) the community services that may be involved; and 3) the services that may be provided by mental health technicians in smoothing the transition of the child back into society.

RESIDENTIAL TREATMENT CENTERS

Residential treatment centers are not cure-alls for the emotionally disturbed child. They can only help the child to the point where he can

function appropriately enough to be returned to the community. There is no assurance that the child will be able to adjust socially to the individuals in the community. His past experiences with adults are not encouraging. Except for the child's experiences in a treatment center, his experiences with adults, whether at home, in foster homes, in schools or through other contacts, have been predominantly negative.[1]

Many pre-adolescents have been in several foster homes before they were admitted to the treatment center. Their experiences in these homes have generally not been conducive to the establishment of a socially beneficial relationship with either adults or children. The lack of such firm relationships makes them incapable of functioning effectively in the community.

For the first time in their lives, many of these youngsters have been able to build meaningful relationships with one or more adults in the setting of the residential treatment centers. Unfortunately this relationship is abruptly terminated when the center determines that the child is ready to leave and a suitable placement facility is available.

The effect of such a typical action is expressed by the five year old little boy who was being discharged with less than twenty-four hours notice and no advance information about the place to which he was being sent. He said of the going-away party in his honor, "This is my give-away party."

The emotional complications of such abrupt separations affect the child as well as those taking care of him. The Child-Care Workers are particularly vulnerable. They have been intimately involved in the treatment plan of the emotionally disturbed child. It is expected that with so much investment of himself in the program, the Child-Care Worker would like an opportunity to follow the child through the transitional period from institutional to community living. For the child, the abrupt transition to community placement may be more than he can comfortably tolerate without support from a trusted adult.

There is little or no feedback or lines of communication established between the centers and the placement facilities to follow the progress of the child. The communication between residential treatment centers

and resource agencies is minimal regarding types of placement available, the structure of the placement, pre-placement visits, after-care follow up, and so forth. The resolution of this problem is the responsibility not only of the residential treatment centers but also of social service agencies, both public and private, and the general public.

GROUP HOMES VERSUS FOSTER HOMES

In a proposal submitted to the board of directors of a former orphanage, Mr. Jimmy D. Williams, Director of Children's Treatment Center, Colorado State Hospital, clearly stressed the urgent need for more group placement facilities in the community. Appropriation of sufficient funds to fulfill this need remains a constant problem. Although this paper was more concerned with the adolescent age group, for all practical purposes the pre-adolescents should also be included.

Mr. Williams recommended that such a placement facility provide specialized group care services for children of both sexes throughout the state who need living experiences of adult identity, peer orientation and relationships but who cannot use or accept a close family relationship. This service is to be provided on three levels: partial group care experience in acute crisis, full residential group care for a short term, and full residential group care for a longer period of time until they can assume a semi-dependent or independent living arrangement away from the immediate family and group care facilities.[2]

Foster family care is not the answer for all children. Some children may never be able to tolerate close adult relationships due to adverse past experiences. A group home may be a more durable and secure placement, than a series of inadequate foster homes.[3]

Replication of family life is not always realistic for the majority of disturbed children. We must give full consideration to all factors in determining the relative advantages of specialized group homes, foster homes, and large group homes.

There is great concern about the dwindling supply of available foster homes but even if adequate homes were available this does not necessarily mean this is predominately the best way of caring for emotionally disturbed and neglected children.

Most foster care parents cannot be tolerant and understanding of minor difficulties that arise with the children entrusted to their care. They seem to lack empathy and the ability to comprehend their needs. Under such circumstances the possibility exists for further rejection of the child who has already been neglected, abused and abandoned.[4]

This was supported by psychiatric examination of a group of one hundred and forty children. It was found that the serious emotional problems of these children were attributable in part to foster care experiences.[5] To preclude such unfortunate experiences a trained staff should be available in community agencies to provide the supportive services essential to both the child and foster parents. Unfortunately such qualified, trained staff are in short supply.

The feelings of inadequacy and guilt often shown by natural parents must also be considered. Even though they realize the child can never function adequately as a member of the family, foster home care only tends to increase their guilt. The idea of placement in specialized group homes may relieve some of their anxiety and be less threatening to the family.

Most states have laws regulating child-care outside the natural home. Emphasis is placed on physical aspects such as food, clothing, shelter and adequate medical care. Not enough is focused on the emotional aspects, the human elements involved in his game adults play with children, who are expected to obey and conform to rules set up by society.

Although the physical aspects of child-care have been primary considerations, it is now time to take a closer look at the emotional needs of these children in an attempt to determine more effective methods of helping them.

EXISTING GROUP HOME FACILITIES

There are currently three placement facilities in operation in Pueblo County. One of these will be phased out as a group home in the near future. The facilities are McClelland Children's Home, Sacred Heart Home and Pueblo Youth Center.

McClelland Children's Home, formerly an orphanage, still continues to function somewhat in this capacity. It provides twenty-four hour care for children. Parental contact is encouraged and, whenever possible, the children returned to their homes on week-ends. If their parents are unable to provide adequate meals, the children may return to the McClelland Home for their meals. The home is licensed to care for fifty children. The children range in age from two to fourteen years.

This home is to be phased out of operation over the next few months and the children will be returned to their homes.

Sacred Heart Home is owned and operated by the Franciscan Sisters of Wheaton, Illinois. It has a capacity for sixty children and is divided into six apartments, three each for boys and girls. Each set of houseparents is responsible for two apartments. The children are separated according to age and emotional-social problem. Children with serious physical handicaps and those unable to profit from psycho-social therapy provided by the social services are not accepted for admission.

The long-range goals of this home are to prepare the child for eventual placement. However, if a placement is not effected prior to adolescence, it may be more desirable to continue care at the Home. As an alternative to permanent foster home placement, a relationship may be encouraged on a foster relative basis. Periodic visiting privileges may be granted the foster relative. In this way a meaningful relationship can develop with a family without the demands that may be intolerable to the child in a permanent foster home placement.

Children who, because of emotional problems, are unable to adjust to community schools are provided with a school program at the Home until they can function in public or parochial schools.

The third group home, Pueblo County Youth Center, is also a large institution. It is operated by the Pueblo County Welfare Department. However, boys from other counties in Colorado are admitted. The center is licensed for thirty-four boys, and is treatment-oriented for emotionally disturbed boys within the 12 to 18 year age range. One year residency is usually the minimum stay. If problems within the home are resolved, the boys are returned to their homes. Otherwise they may remain through high school.

Medical services are provided through Medicaid benefits. Spanish Parks Mental Health Clinic provides psychiatric consultation and the Child Welfare Division provides the social services. The treatment program consists of one-to-one and group therapy by social services personnel, although the child may relate with any member of the staff he chooses.

Pueblo County with a census of approximately 135,000 people does not have sufficient specialized group homes to care for either the emotionally disturbed children released from intensive treatment or for the less disturbed children. The combined capacity of the two treatment-oriented homes is eighty-four. This is only a small percentage of the number of children being referred from other counties.

The existing homes are not most appropriate to the needs of the emotionally disturbed children. They are too large. The ideal small group home should have a maximum capacity of fifteen. It should be located inconspicuously in a residential section of the city where the child can maintain closer contacts with adults at the treatment center, until effective working relationships with the staff of the home are developed. Such an arrangement would also provide a more home-like environment in comparison to the institutional environment. By incorporating County Welfare, Spanish Peaks Mental Health Center, Catholic Social Services and Family Services as resource agencies, we could, hopefully, create a closer alliance between the agencies and the institutions.

ROLE AND FUNCTION OF MENTAL HEALTH TECHNICIANS

Ideally, preventive mental health services should be available in the community to detect and identify the developing problems of the child before they require specialized treatment. But when they do need such specialized treatment the full resources of the community should be applied to immediately control the problem. The community should be aware of the resources available or needed to meet the problem.

All private and public agencies as well as institutional facilities should be aware of the capabilities of the Mental Health Technicians and the supportive services they can offer through specialized and generalized knowledge and training. The emotionally disturbed child needs the

assurance that there is always someone available who understands him and can help him.

The Mental Health Technician may be used as a liaison between the child and the adults responsible for him, the school, the church, or other community activities in which he is involved. The technician is qualified by training experience to help the child and his family through individual counseling, family therapy and counseling, group therapy, and interviewing. The Child-Care Worker is a specialized worker in mental health. With additional training and experience he can acquire new skills that can be beneficial in supportive services to other disciplines in the field of mental health.

With the increasing demand for more services, there is a continuing acute shortage of qualified mental health personnel. It is urgent that the community develop and utilize existing classes of workers to their full potential. The Mental Health Technician with his knowledge, skill and training in caring for emotionally disturbed children, should be incorporated into both public and private service under the supervision, and guidance of professional disciplines, to help relieve this manpower shortage. Several facilities have already done this. They have recognized the ability of this group of middle level professionals to function effectively in areas previously considered solely the responsibility of such professional disciplines as social work. In this way they are able to assist the full professionals by assuming some of their ever-increasing workload, thus freeing them to work at higher levels of responsibility.[6]

CONCLUSION

People need to broaden their perspective. To be successful in any endeavor there must be full cooperation and communication between all involved. One cannot be isolated from another.

As mentioned earlier funding for a project such as this is often unobtainable. Due to knowledge of the needs of children, it is our responsibility and moral obligation to make our voices heard in legislative and planning councils, and to persuade authorities of the importance of financing these homes.[7]

A group home developed under professional leadership and staffed with competent trained people, such as Child-Care Workers, should help the agencies, the institutions and the community increase their knowledge of the needs of emotional disturbed and neglected children, and the services that should be provided them. It should help establish a priority basis for developing total resources.[8]

A specialized group home would not necessarily have to be a permanent placement facility but could also function as a half-way house with supportive services provided by Mental Health Technicians. The staff should include personnel trained to help children with emotional problems. Foster home care may be too personalized and large group homes tend to be too impersonal to provide the best care for the child.

The need is for something inbetween. Also needed is more intensive work and communication between residential treatment centers and placement resources, sharing information, pre-placement planning, and post-placement contacts with those whom the child knows and trusts.

Some mental health facilities and public agencies are already considering including the services of the Mental Health Technician in their staffing patterns in the near future. It is the responsibility of the Mental Health Technician to sell himself, through word and deed. We are a "New Breed", and like anything new, we must prove beyond a shadow of a doubt the usefulness and the need for our services.

FOOTNOTES

1. *Children's Need for After Care,* Child Welfare League of America Inc., New York 1966.
2. Williams, Jimmy D., *Specialized Group Care Proposal.* Pueblo, Colorado, August 1968.
3. Eisenberg, Leon, *The Sins of the Fathers: Urban Decay and Social Pathology.* George Banta Company Inc., January, 1962. p. 15.
4. Child Welfare League of America Inc. "Foster Family Care for Disturbed Children" *Child Welfare Journal,* February, 1965. pg. 77.
5. *Ibid.* p. 74.
6. Parsons, John R. *Differential Uses of Clinical Associates in Child*

Welfare Agencies. Child Welfare League of America Inc., December 1968. p. 602.
7. Eisenberg, p. 15.
8. Child Welfare League of America Inc. "Foster Family Homes: Traditional". *Child Welfare Journal,* October 1964. p. 397.

GOALS OF N.A.P.T.

By William Grimm, Executive Director,
National Association of Psychiatric Technology

There is a unity of purpose that gathers together the psychiatric aides and technicians and their friends in other disciplines at Pueblo to share in a fulfilling educational experience. The Workshop embodies the goals of NAPT. Its entire plan symbolizes the total identification of the Colorado technicians with the National Association's objectives. Like NAPT the Workshop has addressed itself to the broad issue of mental health, poverty, youth delinquency, mental retardation and the social problems manifested in alcoholism and drug abuse.

It has demonstrated to a highly receptive audience the techniques and innovative use of personnel that have been developed to help people handicapped by the immobilizing weight of these problems. It has stressed, as NAPT does, the critical part that imaginative, specially tailored educational programs for psychiatric and mental health technicians have in developing middle level professionals to meet the critical shortage in manpower. NAPT and the Workshop have as a common goal to obtain an ever-wider recognition for the increasing competency of the technician and his potential for assuming greater responsibilities and new roles in mental health.

I commend CPTA's members and leaders for their imagination, hard work and perseverance in establishing an outstanding learning program. The Workshop is fast becoming a nationally recognized event to which one looks forward with pleasant anticipation. The Workshop challenges and opens new directions for further thought and exploration.

NAPT, which incorporates an increasing number of affiliates across the nation, has as its primary goal the development and professional recognition of the psychiatric technician.

To achieve this primary goal NAPT turns to educational programs, professional licensing standards, publication, institutes, workshops, personnel staffing standards and legislation. In a world where our activities are circumscribed by local, state and national laws, regu-

lations, standards, taxes, etc. technicians are very much influenced and affected by what goes on at each of these levels. To believe that we only have to worry about what happens at the local level is to put our heads in the sand in a vain hope that what we don't know can't hurt us.

The Association and the destiny of its members is shaped by the needs of mental health and the community at large. This is only natural since psychiatric technicians are part of the therapeutic team administering to the needs of the mentally ill and the mentally retarded. The social problems that produce the greatest burdens for mental health must be the ones that are given immediate, intensive attention. These are the problems of poverty, unemployment, inequality of opportunity and resultant delinquency, alcoholism, retardation and emotional and mental disabilities. As these problems are more fully recognized and understood, we come closer to effective treatment and rehabilitation of their human casualties. These problem areas are the concern of NAPT and its members. Psychiatric technicians must anticipate playing a larger role in such programs.

The goals of the Association are shaped by the emerging concepts of treatment and rehabilitation. These involve not only a greater variety of treatment modalities but also of types of facilities; it is a change from the institutional to the community center. The changes are not automatic, once it is decided that the most effective treatment is to be in the community. There is much planning and coordination necessary to make the transition from the state hospital to a comprehensive community mental health center. Participation in the planning and implementation of such shifts in type and place of treatment must be extended to NAPT and all its members.

The goals of NAPT, finally are shaped by its own programs. These are programs to assure the better utilization of the technician, to create for him a career structure in which he can move continually upward to reach into related areas of activity. They include programs to develop and unite all middle level professions in psychiatric technology and in mental health in an effort to coordinate their activities, develop standards in training and job specifications and enlarge the areas in which they can make their maximum contribution to mental health.

The chronic and critical shortages in mental health manpower are the most compelling reasons for making the best use of this most important source of trained manpower. These shortages force a new look at old ways of doing things. Mental illness is not necessarily a medical problem and we must apply a more relevant model if we are ever to control this devastating human crisis.

The vastness of the problem and the burdens of mental health and mental retardation are manifested in the elaborate and extensive federal programs and legislation. These affect us as individuals, as professionals and as members of professional associations. The psychiatric technicians can only assume the larger role in local, state, and federally financed health programs if he is recognized as a professionally competent entity. Such recognition is never automatic but is accomplished by hard and carefully programmed work at the profession's local, state and national association levels.

Each level of organization, local, state and national, has distinct functions and contributions to make in advancing the psychiatric technician. At the local, "grass roots" level, the chapter members are out to "sell" themselves, psychiatric technology, the local, state and national association to other aides, technicians, mental health workers, other disciplines in the hospital and the community programs, and the concerned public. They participate in community programs to advance mental health and to reduce or control local social problems. Chapters work with each other to strengthen each other's programs. Members should participate in shaping their training programs, in developing innovative programs, in instructing in psychiatric technology, in serving as full members on the therapeutic team, and in working with community agencies in the rehabilitation of patients.

At the state level, the association coordinates the efforts of the local chapters to establish standard educational and training programs, job specifications and performance and salary standards throughout the state. It fosters and supports legislation to develop the professional level and advance the career opportunities and benefits of its members. It plans legislative programs to effect certification and licensure of the psychiatric technician under standards that will permit his continued advancement. The state affiliate works with other state affiliates on a regional basis to develop workshops, conferences and seminars on matters of common interest.

At the national level the actions of the state affiliates are coordinated in a united effort to effect the maximum exchange of information through publications, literature, institutes, and research materials. Guides are furnished to states and individuals to develop local and state programs. Legislation is recommended and supported at the national level that would promote the professional competency and role of the technician and establish a nationwide standard of quality. It is a slow and staggering task to create a uniform standard among a variety of systems that have developed independently and are at different levels of growth. It is part of the national effort, spearheaded by the National Institute of Mental Health, to increase the quality and quantity of treatment through educational, and recruitment programs, research projects, hospital improvement programs and financial support for developing facilities and staff.

There is no end to the task that must be done. There are only the physical limits to the work that we can do at any one time. It calls for our increasing involvement in a greater variety of activities that can influence the development of mental health as well as our own future. Our roles must be extended beyond the hospital, the clinic, the special programs for our patients. We must unite our efforts to bring about changes in legislation and regulations that will benefit the mentally ill, the emotionally disturbed and the mentally retarded. Their benefit will always remain our primary concern; our future is tied to their future.

To become fully and effectively involved in legislation, we must become aware of the laws and regulations that govern our professional life. This includes such important details as licensing, supervision, giving of medications, professional boards, and practices, licensure and certification examinations, salaries, staffing and various fringe benefits. We must know the legislative process in bringing about changes in the law. We must know our present status and needs to determine what legislation and regulations are required to advance the public's and our interest in mental health. We are closest to the patient and should constantly seek to increase the effectiveness of our service to him. What we can do for him is ultimately governed not only by our own competency and imagination but by the funds, staffing and other resources that are allocated to the program. These are often determined outside the hospital, the local community and even the state.

We must be not only a professional but a "political animal" and not leave political decisions that affect our professional and personal life to others. We must speak for ourselves to legislators and choose men who are sympathetic to the aims of mental health and psychiatric technology. The cause of mental health should be non-partisan, it is based on the belief that the well-being and dignity of the individual is our society's primary concern. If we do not do the job, someone else will – and it may not be to our patient's benefit. To be effective we must speak with a common purpose. Our strength is in a united voice that speaks for the greatest number of psychiatric and mental health technicians. This is the strength of NAPT.

ABOUT OUR NATIONAL ASSOCIATION

The National Association of Psychiatric Technology, a non-profit organization, is the outgrowth of local and state organizations of psychiatric attendants, aides and technicians. These local associations were formed to improve their members' skills and knowledge in order that they might provide more effective service to the mentally ill and the mentally retarded. The associations also sought to develop greater roles for the technicians in the state hospitals through upgrading their training and education. The present NAPT was sponsored by one such state association, the California Society of Psychiatric Technicians. The California assoication was established in 1950 by a group of hospital attendants who recognized the need for professional representation. The national association was formed in 1961 to encompass other state associations It is now in a period of expansion to include not only associations of psychiatric technicians but other middle-level professionals in mental health.

The National Association of Psychiatric Technology has as its objective the logical advancement of the middle-level professional in mental health through the development of open-ended career ladders and educational programs that permit entry to all individuals who can and are willing to help the mentally troubled and the mentally retarded. The Association believes the best interests of mental health are served by careers that allow upward and lateral mobility. The continuing chronic shortages in qualified mental health manpower compel the better utilization of existing classes of mental health workers and their continued training to prepare them for increasing resonsibilities in a variety of settings. We believe the problems also require the best utilization of existing mental health facilities while developing a new complex of therapeutic settings – community mental health centers, psychiatric units in general hospitals, day, night, and weekend hospitals, halfway houses, and sheltered workshops. We believe that the psychiatric hospital is, and should remain, an integral, necessary component of the therapeutic continuum. It should be sensitive to social change and continually reappraise its role to assure the best service to the mentally disordered, the emotionally disturbed and the mentally retarded.

NAPT strives to attain its objectives through the establishment of a code of ethics to regulate the personal and professional conduct of its members with other professional, the patients and the public. Through standards for training and educational programs, training materials, workshop and institutes it seeks to quality the workers in mental health for more effectively fulfilling their responsibilities and prepare them for greater roles in this rapidly expanding field of human services. It encourages continued scientific study to develop and improve therapeutic and rehabilitative techniques that would extend the competencies of the technician. In pursuit of its objectives it maintains professional and informational liaison with educational institutions, professional and lay organizations, and governmental agencies at all levels that are concerned with or responsible for preventive, therapeutic and rehabilitative programs in mental health. It sponsors and supports legislation to enhance the individual and the professional status of its members and to increase the scope and effectiveness of mental health programs.

We invite all psychiatric aides and technicians, mental health technicians and assistants as well as individuals in other therapeutic and rehabilitative or habilitative services for the mentally and emotionally handicapped to join NAPT and assist in advancing its goals. For further information regarding NAPT write or telephone the National Association of Psychiatric Technology, 1127 11th Street, Sacramento, California 95814. Telephone (916) 444-2452.

OTHER NAPT PUBLICATIONS

You may be interested in obtaining copies of the following NAPT publications relating to roles, functions and training of psychiatric technicians in mental health:

Mental Health Manpower and the Psychiatric Technician

This compilation of presentations made at an NAPT institute includes:

"Mental Health in California: The Dynamics of Revolution"
"Mental Health Manpower in Transition"
"A Symposium on federal and state regulations which affect staffing standards for nursing services in state and local facilities."
"Legal Aspects of Utilizing Psychiatric Technicians in Mental Health Services."
"Private Psychiatric Hospitals"

Price: $2.00

Community Mental Health and the Psychiatric Technician

It includes pioneer work in developing new roles and training programs for middle-level professionals in mental health:

"Purdue Trains Mental Health Workers"
"Maryland's Design for a New Health Career"
"New Careers Program in Mental Health"
"California's Search for College Programs for Psychiatric Technicians"
"Role of Community Mental Health Workers"
"The New Era in Medicine"

Price: $1.75

Copies of these publications and additional copies of "New Frontiers in Psychiatric Technology" may be ordered from the National Association of Psychiatric Technology, 1127 11th Street, Sacramento, California 95814.

APPENDIX I

Metropolitan State College
250 West 14th Street
Denver, Colorado 80204

CURRICULUM FOR HELPING SERVICES PROGRAM
(Mental Health Worker)

FALL	CREDITS
English 101	3
Biology 101	4
Psychology 101	3
Sociology 101	3
HSW 101 (Introduction to Helping Services)	1
	14
PE 101 (Physical Education)	1

WINTER	CREDITS
English 102	3
Anatomy and Physiology	4
Psychology 102	3
HSW 102 (Community Resources)	1
	14
PE 102	1

SPRING	CREDITS
English 103	3
Anatomy and Physiology	4
Psychology 221 (Human Development)	3
HSW 103 (Helping Services Agencies Practice)	3
	13
PE 103	1

Total Credits: 41 + 3 (Physical Education)

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SUMMER	CREDITS
PS 299	1 Hour – Field Experience at Participating Agency
HSW 201	3 Hours – Principles Applied to Helping Services

FALL	CREDITS
*Electives	.6
Sociology 201 (Social Problems)	.3
Sociology 210 (Urban Sociology)	.3
HSW 202 (Principles Applied to Helping Services)	.1
*Humanities	.3
	16

WINTER	CREDITS
*Electives	.3
Sociology 202 (Social Problems)	.3
Sociology 211 (Urban Sociology)	.3
HSW 203 (Applied Helping Services I)	.8
	17

SPRING	CREDITS
*Electives	.5
Social Psychology	.3
HSW 204 (Applied Helping Services II)	.8
	16

Total Credits: 49

***Recommended Courses**
January 1969

APPENDIX II

Southern Colorado State College
900 West Orman Avenue
Pueblo, Colorado 81005

Mental Health and Psychiatric Technology
Curriculum
First Year

FALL	CREDITS
Rdg. 125 Developmental Reading	.2
MH 101 Introduction to Psychiatric Technology	.8
MH 106 Clinical Work Experience I	.4
MH 111 Basic Nursing Concepts I	.3
	17

WINTER	
Eng. 101	.3
MH 102 Psychiatric Technology	.8
MH 107 Clinical Work Experience II	.4
MH 112 Basic Nursing Concept II	.2
	17

SPRING	
Eng. 102	.3
MH 103 Advanced Psychiatric Technology	.8
MH 108 Clinical Work Experience III	.4
PE 232 First Aid	.2
	17

Second Year

FALL	CREDITS
Soc. 101 Principles of Sociology	.5
Biol. 101 College Biology	.4

MH 201 Families in the Social Structure 3
MH 206 Mental Health Practice I 2
MH 221 Mental Health Skills – Interviewing 3
P.E. (Physical Education) 1
18

WINTER

Anth. 102 Introduction to Anthropology 5
MH 202 Group Process Laboratory 2
MH 207 Mental Health Practice II 2
MH 222 Mental Health Skills – Family Therapy 2
P.E. (Physical Education) 1
* Electives 6
18

SPRING

Eng. 103 3
SP 101 Fundamentals of Speech 3
MH 203 Community Action for Mental Health 2
MH 208 Mental Health Practice III 2
P.E. (Physical Education) 1
* Electives 7
18

Total Credit Hours: 105

* Humanities and science requirements for the AA degree are met by selecting appropriate electives.

NOTE: Programs have two main goals: (1) Training of psychiatric technicians in a nine-month segment which prepares the student for licensure and employment as a licensed psychiatric technician, and (2) training mental health technicians in a two-academic year segment which leads to an Associate in Arts degree.

NEW FRONTIERS IN PSYCHIATRIC TECHNOLOGY

COLORADO PSYCHIATRIC TECHNICIANS ASSOCIATION
415 North Grand, Pueblo, Colorado 81003

NATIONAL ASSOCIATION OF PSYCHIATRIC TECHNOLOGY
1127 11th Street (Main floor)
Sacramento, California 95814